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ABSTRACT

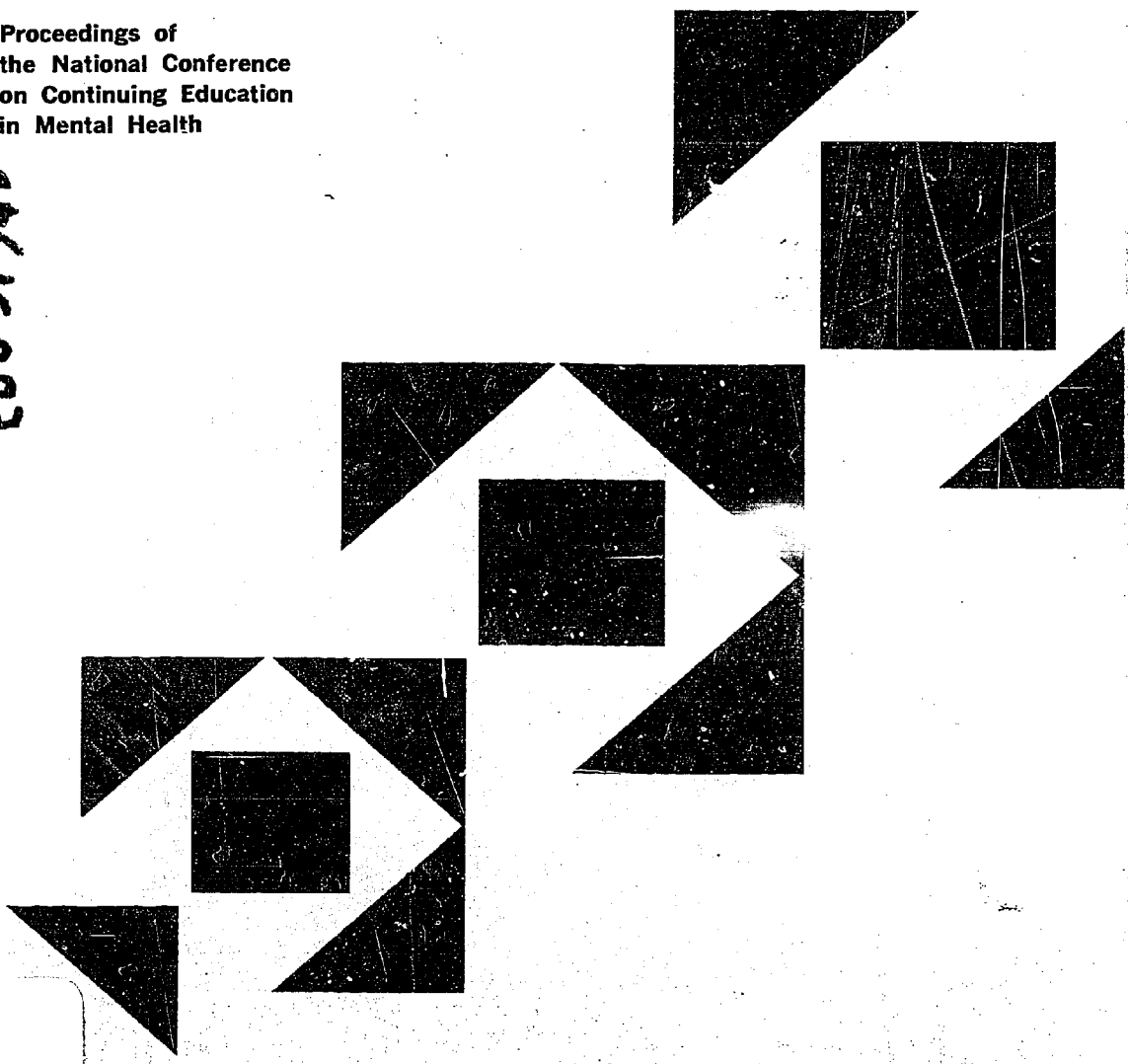
This document focuses on the theme that rapid social and technological changes add urgency to continuing education in all fields, particularly in the field of mental health. For the purposes of this conference, continuing education was defined to include postgraduate education, staff development, inservice training, and adult education. For these purposes, mental health was defined to include health promotion and illness prevention and treatment and the business of families, communities, States and nation, even while the ultimate focus is upon individuals. Broad objectives of the conference included: (1) to identify continuing education needs; (2) to suggest priorities, or methods, which administrators could use to arrive at appropriate objectives for their organizations; and (3) to provide mental health administrators and educators greater familiarity with continuing education expertise which is available. The following major points of emphasis characterized the conference: (1) diversity of resources and concerns for continuing education in mental health, (2) unusually broad definitions of continuing education and mental health, and (3) involvement of the adult learner in the process of assessing needs. Highlights of the conference evaluation indicate that there were individual extremes of praise and dissatisfaction, and that considerable participant learning occurred. (Author/CK)

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CONTINUING EDUCATION: agent of change

Proceedings of
the National Conference
on Continuing Education
in Mental Health

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CONTINUING EDUCATION: agent of change

**Proceedings of
the National Conference
on Continuing Education
in Mental Health**

Sponsored by
Continuing Education Branch
Division of Manpower and Training Programs
National Institute of Mental Health

In cooperation with
The University of Chicago
Center for Continuing Education
October 25-27, 1967
at the University of Chicago
Center for Continuing Education

Edited by
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Preface

Continuing education is receiving increased emphasis in all occupations due to rapid advances in knowledge and technology, accelerating socioeconomic changes, and pressing manpower needs. The field of education is itself undergoing changes in theory and methodology. Educators are striving to incorporate advances in communications, human systems design, and learning technology; they are also stressing continuity, individualization, learner involvement, lifetime learning, social relevance, program effectiveness, and behaviorial change. Continuing education is especially well suited to serve as a bridge between academic centers and service organizations, a bridge for which there is increased urgency.

Effective manpower utilization is pivotal for implementing new mental health programs now being developed as a result of recent Federal, State, and local legislation and planning. The National Institute of Mental Health, as part of its reorganization in 1966, established a new Continuing Education Branch in the Division of Manpower and Training Programs. A new continuing education grant program was initiated.

The National Conference on Continuing Education in Mental Health provided a timely interchange among experts with a variety of perspectives on education, manpower, and mental health programs. The conference was planned and sponsored by the Continuing Education Branch of the National Institute of Mental Health, with the valuable assistance of an advisory committee and other consultants. The University of Chicago Center for Continuing Education provided an excellent setting for the conference. The center staff contributed greatly by their services and cooperation in the conduct of the conference and the preparation of the proceedings.

The proceedings which follow, like the conference itself, provides a fresh perspective and significant emphasis on continuing education as an agent of change. Suggestions for planning and action at local, State, regional, and national levels have already proved helpful to many of the participants and their organizations. These published proceedings should be of value to a much wider circle of persons concerned with continuing education and more effective manpower utilization in the field of mental health.

The editors are particularly indebted to Miss Susan Cullen of the University of Chicago, Mrs. Norma Miller and Mrs. Martha Kovacic of NIMH for editorial assistance. Mrs. Jeanette Nehren, who joined the NIMH Continuing Education Branch after the conference, was also of great assistance in editing the proceedings. For the many hours of secretarial assistance in arranging and reporting the conference, we are particularly indebted to Mrs.

Ruby Kaster, Mrs. Tobie Weinberg, Mrs. Beatrice Sandler, Mrs. Georgia Lund of NIMH, and Mrs. Beverly J. Williams, Miss E. L. Waller, and other secretaries of the University of Chicago Center for Continuing Education.

For planning and conducting the conference, the staff of the Continuing Education Branch of the National Institute of Mental Health are particularly grateful to Mr. James Lawrence and Dr. Lucy Ann Marx of the University of Chicago Center for Continuing Education, members of the Advisory Planning Committee, the NIMH Continuing Education Training Review Committee, conference collators and group leaders, Dr. William Griffith of the University of Chicago Department of Adult Education, and graduate students from that department who served as group reporters. Last but not least, the success of the conference rested with the excellent contributions of the participants.

THE EDITORS.

Introduction

"Continuing Education, Agent of Change" was the theme selected for the 1967 National Conference on Continuing Education in Mental Health. This theme emphasized the rapid social and technological changes which add urgency to continuing education in all fields. The theme also emphasized that imaginative planning and training methods are essential if continuing education is to fulfill its potential as an active agent in the behavioral and organizational changes which must accompany technological advances. The necessity of behavioral and organizational changes is nowhere more true than in the mental health field. The theme also implies that continuing education itself is subject to change. Advances in learning technology and organizational effectiveness can transform continuing education from a traditional stereotyped system of courses into a more dynamic medium for the adult learner. He learns, and participates in the problem-solving process with which he must create the future, while adjusting to the rapid changes of the present.

Continuing education has many meanings, and questions of definition arise early in most discussions of the subject. For purposes of this national conference, continuing education was explicitly and broadly defined to include postgraduate education, staff development, inservice training, and adult education (see appendix A). During the national conference, continuing education was also implicitly defined to include adult experimental learning, career development, behavioral, organizational, and social change, as well as information acquisition and technological change. The latter implicit definition was, of course, consistent with the stated theme of the conference.

Mental health also has many meanings. For purposes of this national conference, mental health was implicitly defined by the selection of participants and conference design. The proceedings convey an implicit definition of the mental health field which includes health promotion and illness prevention as well as treatment; another implication is that mental health is the business of families, communities, States, and the Nation even while the ultimate focus is upon individuals. A further underlying assumption at this conference was that continuing education in mental health is the concern of private as well as public organizations, of citizens and paraprofessionals as well as professionals, of politics and economics as well as education, and of many overlapping fields in addition to the mental health disciplines.

The above definitions and assumptions were significant factors in the

minds of the planners who saw a need for this type of National Conference on Continuing Education in Mental Health. Following establishment of the new Continuing Education Branch and grants program by NIMH in 1966, the NIMH staff and two ad hoc advisory committees addressed themselves to questions of sound planning and financial investing in this field. They noted the part-time, and spotty nature of continuing education staff and activities in universities, mental health training centers, professional organizations, and service agencies, and the relative isolation of mental health personnel and organizations, despite fine examples to the contrary. They noted the dedication of mental health professionals to ideals of lifetime learning, and they noted examples from other fields, such as industry and agriculture, which have made continuing education a very practical and significant investment for their own enlightened self-interest and for adaptation to technological and social change. The relative paucity of support for continuing education by universities, service agencies and their funding bodies is not in the enlightened self-interest of these institutions, the recipients of mental health services or those who pay the bill.

The advisory committees also noted the relative persistence of postgraduate courses styled on the information dispensing model of education and the delay in application of basic principles of adult education and newer learning methodology. At the same time, they noted aroused interest, leadership, and readiness for more intensive programs of continuing education within the mental health field and in related fields.

They were acutely aware of the manpower and funding shortages in continuing education just as in other endeavors, yet they felt that these shortages were precisely the reason for developing more effective programs of continuing education and manpower utilization on a broad front. The national conference was seen as an essential stimulant for a more concerted effort at planning and developing continuing education in mental health.

Members from previous ad hoc advisory committees and other consultants provided excellent contributions to the planning of the conference. The objectives developed by the Advisory Planning Committee were:

1. To identify continuing education needs as perceived in the field by the participants.
2. To suggest priorities, or methods, which administrators could use to arrive at appropriate objectives and priorities for their organizations.
3. To provide mental health administrators and educators greater familiarity with continuing education expertise which is available, and to provide continuing educators from other fields greater awareness of needs and resources in the mental health field.
4. To define the concerns and program of the National Institute of Mental Health in continuing education and to gain suggestions for future NIMH activities.

5. To develop models and suggestions for plans and actions at local, State, regional, and national levels.

During the conference the objectives were further specified in terms of the expected "take-home" for individual participants from within and outside the mental health field:

1. To become better informed about continuing education as a type of education, its potential and methods as an agent of change.
2. To become better informed about problems of mental health manpower and continuing education in mental health.
3. To identify a plan of action for organizations.
4. To plan how their organizations might work with other local, State, regional, or national efforts.

The selection of participants was crucial to the uniqueness and purpose of the conference. The Advisory Planning Committee planned on 100 participants, 10 representatives from each of the following categories.

1. Experts in the field of continuing education (from outside the mental health field). Also specialists in research and evaluation of continuing education.
2. Deans or department chairmen, educators from mental health professions.
3. Directors of mental health continuing education programs.
4. State mental health authorities, commissioners, regional representatives, etc.
5. Local and/or institutional mental health administrators, e.g., directors of city and county mental health programs, directors of community mental health centers or superintendents of hospitals.
6. Professional associations and/or certifying groups.
7. Continuing education learner-consumer interests not otherwise represented, e.g., persons engaged directly in clinical practice or other delivery of mental health services, or their organizational representatives.
8. Citizens groups and service-consumer interests, e.g., representatives of citizens organizations, citizen advisors to governmental agencies, members of mental health boards, trustees, labor unions, etc.
9. Representatives from Federal agencies other than NIMH, particularly persons who are experts in continuing education or hold official responsibilities for manpower, communications media, and education.
10. NIMH staff from a variety of branches and divisions.

The Advisory Planning Committee designed the conference to provide an optimum of interchange and a minimum of passive listening. Formal addresses were planned only as initial stimulants and orientation for the conference, plus one summarizing sendoff speech at the end. The two intervening plenary sessions were brief and functioned primarily to provide unity and continuity, while the main business occurred in small group sessions.

The following are major points of emphasis which characterized the conference and its impact on participants. These points are based on a review of the complete proceedings, evaluation responses from participants, and known activities of participants since the conference.

1. *Diversity of resources and concerns for continuing education in mental health.* The diversity of contributions and concerns is evident from the roster of participants, the content of plenary sessions and small group discussions, and the evaluation. The conference was unique in bringing together representatives from these diverse fields and in providing for the exchange of information and viewpoints relevant to continuing education in mental health.

2. *Continuing education and mental health were both more broadly defined than is common in existing mental health continuing education programs.* This was partly by design, as described in this introduction and in appendix A, and partly the product of the varieties of expertise represented at the conference. Differences in terminology and concepts, provided stimuli for clarification and fruitful exchange throughout the conference.

3. *Involvement of the adult learner* in the processes of assessing needs, planning, conducting, and evaluating continuing education programs was emphasized repeatedly in plenary and small group sessions. This has been implemented in a variety of activities by participants subsequent to the conference. A related theme was the involvement of *employers, consumers of health services, citizen groups, and other representatives with vested interests* in determining the relevance and priorities for continuing education programs. The involvement of such interest groups was seen as useful mutual education and as a significant part of the decision making process. Greater involvement of learners and other interest groups was also seen as a corrective to the narrower aspects of professionalism, professorism, disciplinary rivalries, town-grown problems, and the limitations of traditional post-graduate education courses.

4. *Individual needs, motivation, learning process, identity development, and behavioral change* were discussed from a variety of adult educational and psychological perspectives. The relation of the individual to small group teams, to larger work-related organizations, and to society was seen in many contexts as crucial for adult learning and adaptation to change. A dynamic equilibrium of motivational factors exists; such factors were viewed as a source of resistance to learning and yet the key for fostering learning, growth, and change. Probably the strongest area of consensus between adult educators, mental health educators, administrators, and practitioners was the importance of affective learning, experiential learning, and behavioral change as compared to the overemphasis on cognitive learning which still characterizes many educational programs.

5. The *planning and organizational aspects of mental health continuing education programs* recurrently arose as crucial for adult learning, educa-

tional program vitality, improved mental health services, and social change. Several participants described specific political and economic considerations relevant to continuing education and mental health. Continuing education in decisionmaking and problem solving were among examples from the industrial management development field which would be relevant for mental health administrators. (For examples of contributions from educators in industry see plenary speech of Dr. Cron and background paper by Mr. Mobley in appendix A.) Demands for improved mental health services, in spite of limitations in mental health manpower and funding, were described as mounting pressures which require greater emphasis on strategies and priorities in manpower utilization and continuing education. The need for integration of continuing education programs into high priority community and State mental health plans and services was recurrently stressed, particularly by participants with responsibility for mental health plans and services and by representatives of consumers of services. Suggested guidelines and diagrams were developed by several of the small groups. The need for closer collaboration between university and service agencies was frequently voiced, and continuing education programs were cited as a most natural medium for collaboration. Funding for continuing education was also seen as closely tied to its demonstrable relevance for improved delivery of services. Experts on organizational behavior, organizational change, group process, management development, adult education, institutional administration, community organization, and milieu therapy found much common ground for relating adult learning and behavioral change to the human environment of the work organization. Continuing education for mental health administrators, for key citizen leaders such as board members and legislators, for mental health professionals who must train and work with new types of mental health technicians and for directors of continuing education programs were all seen as strategic for impact via organizational change.

Since the conference, a number of the participants have been engaged in more concerted efforts to integrate continuing education plans and activities into organizational changes and improved administration of mental health services. Others in allied fields have reported informally that participation at the conference stimulated them to reexamine their own programs and, as a result, mental health content has been introduced.

6. *Advances in educational technology* were cited, and a few were demonstrated during the conference. Experts in communication systems, audio-visual technology, educational television, adult education methodology, programmed learning, etc., contributed to discussions and to elective demonstration sessions. Educational technology was not a prominent feature of this conference, yet many participants from the mental health field were made more aware of advances and resources outside the mental health field. Several resource persons who had relatively little contact with mental health training programs prior to the conference have been more actively involved in mental health programs since the conference; in other instances mental

health participants in the conference have subsequently, and for the first time, called upon outside resource persons similar to those encountered at the conference as well as on actual conference participants.

7. *Suggestions for regional and national program organization for continuing education in mental health* were made and discussed at the conference, including recommendations to NIMH (see part three). Subsequent regional activities and conferences, particularly those sponsored by Western Interstate Commission for Higher Education, and Southern Regional Education Board, and national activities sponsored by NIMH, American Psychiatric Association, American Academy of General Practice, Council on Social Work Education, and other professional societies and Federal agencies have been definitely influenced by the conference (see "Conference Evaluation and Followup," part three).

8. *The roles and contributions of universities, university extension divisions, schools of adult education, and schools for the mental health professions* were well represented and elaborated. For most mental health professionals only the contributions of their own professional schools are well known. The evaluation and contributions of university extension divisions (for example, see plenary speech of Dr. McNeil) and of adult education (for example, see contributions of Dr. Knowles in appendix A, Dr. Griffith in group D, and Dr. Sheats and Mr. Pagano in group G) are less well known to mental health professionals. Important contributions of universities to evaluation and theory relevant to continuing education were described and discussed. Subsequent to the conference there have been many examples of increased liaison between adult educators and mental health educators.

Much of the above also pertains to *contributions from representatives, of private industry and from representatives of Federal agencies outside NIMH.*

9. The conference provided *repeated emphasis on interdisciplinary collaboration and reflected prior evolution of the interdisciplinary field and of governmental-nongovernmental collaboration.* For example, see the remarks on pages 97-98, in which note was made of the evidence at the conference that interdisciplinary rivalry and status concerns were minimal and that NIMH was regarded as a partner rather than feared as taking everything over.

10. *The conference served as a demonstration in the use of conferences as a variety of continuing education.* Preliminary background materials, a large amount of reference material contributed by participants and available at the conference, elective demonstrations of newer methodologies, evaluation and followup evidence of change were utilized in addition to the mutual education built into the design of regular conference sessions.

Highlights of the evaluation indicate that: There were individual extremes of praise and dissatisfaction with selected aspects of the conference; there was considerable consensus that a flaw in the design was excessive "summarizing of summaries" and "reactions to reactions;" considerable learning and significant changes in subsequent behavior of many participants

occurred by virtue of the diversity and competence of participants; the conference was generally considered above average by the participants, who for the most part were experienced conference participants.

THOMAS G. WEBSTER, M.D.
Chief, Continuing Education Branch
Division of Manpower and Training Programs
National Institute of Mental Health

PART ONE

Proceedings of Plenary Sessions

First Plenary Session

WEDNESDAY MORNING

OCTOBER 25, 1967

WELCOME

THOMAS G. WEBSTER, M.D.
Conference Chairman, Presiding

KNIGHT ALDRICH, M.D.
Session Chairman

LUCY ANN MARX, Ph. D.
Director, Center for Continuing Education

BERTRAM S. BROWN, M.D.
Deputy Director, National Institute of Mental Health¹

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International Business Machines Corp.
excerpts from address
"Changing Technology and Changing Men"

WELCOME FROM CENTER FOR CONTINUING EDUCATION, UNIVERSITY OF CHICAGO

Lucy Ann Marx, Ph. D.

When William Rainey Harper, the founder of the University of Chicago, first opened the doors of the university, he also opened a series of courses that were called an extension program for adults. In 1963, with the aid of the Kellogg Foundation, the university opened this Center for Continuing Education.

The Center has four purposes; the first is to provide an opportunity for scholars and public people to discuss seriously current public issues of crucial importance. For example, the China Conference that was held here a couple of years ago, the Draft Conference, held last year, and just last May the Model Cities Conference.

A second purpose is to provide an opportunity for scholars to talk together and share new research findings. We are now planning a Conference on Adult Education—new ideas, new concepts, new research—in this field.

The third purpose is to provide a laboratory for the training of students in

¹ Now Director, NIMH.

adult education who are concerned with the processes and conduct of adult education activities.

The fourth purpose is to provide an opportunity for professional development and the discussion of issues relevant to a particular professional field.

I welcome you to the Center for Continuing Education. I hope that our center will serve you well as a total learning environment.

WELCOME FROM NATIONAL INSTITUTE OF MENTAL HEALTH

Bertram S. Brown, M.D.

The theme of this conference, "Continuing Education, Agent of Change," is particularly apt, for the name of the game nowadays is change—scientific change, technological change, social change, or organizational change—and this change game leads us to the statistical gamesmanship approach. I did some calculations in the mental health manpower field along the statistical gamesmanship approach, and there are more people in psychiatric residency now than there were psychiatrists all over the United States in 1946, just 20 years ago. There is this kind of change in the manpower field.

One of the most characteristically expanding and changing fields has been the mental health field.

The changes are dramatic. As you know, for perhaps a hundred years the number of residents in State mental hospitals had gone up, reaching its peak in 1955 of 570,000 plus. In the last 11 consecutive years, the number of people on any given day in our State hospital system has gone down. It has now just dipped below 400,000. If the trend had continued, say the 1945 to 1955 trend, we would have had well over 700,000 people in our mental hospitals. We have just dipped under 400,000. This decrease, of course, is a rather impressive thing when we go to Congress for money each year because the cost of the new buildings alone would have been in the billions of dollars.

There is this complex problem of why this turnback took place, which is not a simple matter. It may have been the advent of the tranquilizing drugs. It may have to do with community attitudes, new treatments, general hospitals admitting patients. More patients are admitted for psychiatric services in general hospitals, as first admissions, than to our State hospital system. The remarkable growth in just a period of 4 years of the community mental health center may be another factor. At the present time Federal funds are available and have been given to almost 300 community mental health centers in 48 States in the Union.

I had some special thoughts on continuing education in terms of its relationship to community education, such as this center represents. I felt that an intriguing and vital issue that might engage the energies of this conference

is whether the practice and experience of continuing education endeavors in mental health will contribute in a unique way to the broader field of community continuing education in other fields.

If one views continuing education as a behavior-changing process, what impact will continuing education have on mental health professionals who, at least theoretically, are in the behavior-changing business? What do we as mental health professionals have to bring to continuing education? What does continuing education in other fields that we know about have to bring to us? The analysis of this particular issue led me to a very interesting, at least to me, thought: where is continuing education carried on? When I say where, I mean physically and geographically.

I'd like very briefly to describe a continuing education adventure of my own. I've been teaching postresidency psychiatrists at the Washington School of Psychiatry. With an average age in their middle thirties, they are taking a course in social and community psychiatry. They range from people 2 or 3 years out of residency to the chiefs of psychiatry of the Air Force and the Army who are trying to learn the social psychiatry field. The first semester is on the history of analytic social community psychiatry. The second semester, running for 16 weeks, is on the consultation process to which the usual visiting lecturers are brought in.

I decided that they had seen too many mental health professionals, too many psychiatrists and psychologists, and that they ought to learn something about the community power structure. Hence, we had a straight course on power, starting with the mayor, the head of the urban league, the Bureau of the Budget man, the housing man. They found the seminars and the meetings with these people quite an interesting and exciting experience. Afterwards we went out into the field to places like the Maryland State Legislature to see what lobbying was about, how laws are passed and how an emergency commitment law is placed. Some ethical issues and some challenging issues arose as to whether or not the Washington School of Psychiatry could send people to the legislature. Was this legal? It got very complicated. But the students were welcome as citizens.

The second year, during the same course, we changed the focus somewhat to group power. This time, then, they will meet with judges, the mayor, and others, focusing on antisocial behavior, which I feel is the most pressing issue of our day. Field experience will be going out to the courts, to the jails, and having them actually defend indigent people in terms of the psychiatric conditions that they find. This is more than teaching.

At 4 o'clock this morning I got up and visited the 16th district and spent three hours looking around this particular area. I took a ride on the "bum" car. That's what it's called here. It's called an umbrella wagon officially. It's a wagon that goes about the streets right around this neighborhood picking up the derelicts, drunks, psychotics, and persons dead on arrival. These are people right around the neighborhood. And if you just walk the

streets—and I'm talking about one or two blocks from here—you find the painful human condition, the human comedy, not of Balzac but of Woodlawn. The perfidy against the walls of the burnt-out houses; the boss pimps; the supreme maniac; and the Rangers. Finally the last group I ran into were the "psychospecters"—for the last call I participated in related to two neglected, abandoned children whose mother the sergeant had finally found. These kids were without food; the police bought some food for them and returned them to their mother. It obviously was a bad condition, and I wondered about the practical psychiatry that could have been applied in this situation.

So, ladies and gentlemen, the stimuli are there and the need is great. The challenge to this group is how we can conceptualize and organize the change to meet these great demands of unfulfilled human needs and aspirations.

CHANGING TECHNOLOGY AND CHANGING MEN

Excerpts from the address by
Dwayne Orton, Ph. D.
International Business Machines Corp.

Dr. Aldrich, ladies and gentlemen, I approached this assignment with some fear and trepidation. I am deeply concerned about the complexion of this audience. In the areas that you represent, in the general field which is your concern, you have great opportunities for leadership in the field of continuing education. You are well informed in the areas of the continuing development of that quality of human experience upon which we are even more and more to depend in the coming decades.

So my fear turned to challenge and to the prospect of a thorough give-and-take that will be of great benefit to me. I hope as I go about this process of keynoting, you will regard it as open ended. My remarks about a few fundamental currents of change, which bear upon our concern in this conference, are not conclusive. I hope you will think of them as open ended because the content of what I want to say is open ended, i.e., not complete. It is becoming. Conclusions are dangerous.

I come to illustrate in the context of these fundamental issues, materials largely out of the field of business. I think that the field of business has moved far in this matter of continuing educational development of people.

I take my cue from a statement which has meant very much to me—the statement which in a sense drew me out of academia into the challenging field of continuing education within the context of business. That statement is one which is credited to the genius that developed our company when he said that "to build a business you must first build people."

There are many ways in which we have been attempting to express that

idea. One that I want to share with you is an expression of the manner in which continuing growth and development of people is being discovered in practical terms in the field of business.

Let me show you an advertisement which appeared in many of our national magazines, by the Allegheny Power Co. It is designed to sell power. It not only wants to sell power, but it wants you to locate in their territory so that you can buy power from Allegheny.

It shows a great big "A" in the center of the advertisement. There a young man stands alongside the "A," and about the base of the letter they have put the college and university pennants of the institutions that are located within the area of Allegheny Power.

Ordinarily, when one tries to sell geography for the purpose of establishing plants and laboratories, he finds what in this ad they put into two-and-a-half lines covering the physical facts: "The decisive data you and your staff need on raw materials, markets, workers transportation, water, power, fuel, and plant sites." Now, these are the bases upon which people decide to make capital investments in productive or in research institutions. "But," continues the ad, "the other reason involves the intangible climate of growth, an area's assets in homes, schools, colleges, research centers. These determine whether or not your organization can attract and hold engineers, scientists, and men of top management caliber.

"Look at the academic facilities of this area, then at the firms locating their research and development centers here." And here is the key line. "The intellectual climate of growth makes the great difference."

I submit to you that 10 years ago no economic institution would have been arguing its case on such a basis. This is one little facet, only one illustration, to be sure, out of a particular specialized area, of what is burning its way into the thinking of business.

To build a business you must first build people. To build a hospital staff, you have to build people.

Continuing education work is a mainstream, not a tributary. It is becoming an essential function of our social structure. Let us then, look at some changes in society that indicate this fundamental function of continuing education.

The first of these is the evidence of a generic change taking place in our society which is found in the imperative demand for a "future's orientation" in the thinking of modern man. As the White Queen put it in "Through the Looking Glass": "It is a poor sort of memory that only looks backward."

You know as well as I do about the mushrooming of ideas about the future. Heilbroner wrote a popular book called "The Future as History." Daniel Bell made a list of 24 very significant monographs and dissertations to indicate the great attention now being paid to a future's orientation. The Ford Foundation is supporting a resources of the future project and the American Association for the Advancement of Science has a commission on the year 2000.

The relationship of technical change to this orientation is seen in many simple ways. I will only indicate briefly the things which I am sure are very much in your attention. One is the shift in the character and nature of jobs. The Dubold organization projects that 60 million jobs will change their character in the ensuing decades.

You, yourselves, are in the midst of this kind of change. The shift, for example, in the hospitals, which I know only as a patron in eight trips to a hospital in the last 5 years. I have seen the nurse becoming more of a manager and a paper worker and less an attendant at the bedside of a patient. That may be at the very heart of the reorganization of the nursing profession.

Job obsolescence is not merely obsolescence in terms of changes in jobs. It means changes in the people. One simple illustration in the field of civil engineering was spelled out by Dr. Spellman at Carnegie Tech. He pointed out that in 10 years of experience in the civil engineering curriculum they had discovered that 25 percent of the content of the curriculum was inapplicable at the end of the decade. But they had added new content at the rate of 10 percent per year. The professional civil engineer must constantly continue his education just to keep up. His future orientation is through education.

I am suggesting that these shifts requiring a future's orientation were not required in an older more stable society. However, change is not some detached phenomenon to be watched as a comet in the sky. The many effects of the automobile illustrate this. It has dominated human life for the last 50 years. The tremendous shifts in society brought about by the auto have profoundly altered human life whether we as individuals want it or not.

You are interested in the shifts taking place in the family. The patriarchal family seems to be disappearing. The growth of women in work and the shift in the attitude of children toward the "heads" rather than the "head" of the family are far reaching. These have brought deep shifts in values and in systems of values throughout the past century. The shifts in our sexual mores and the conduct of our personal sexual life are related to the automobile. The new family springs from the changing technology of work, biochemistry, genetics, transportation, communications, entertainment, and others.

Work concepts are changing. There is movement away from the old ethic that a man earns his rights to life by the sweat of his brow, where productivity was the real sine qua non of a man's status, to the concept that man's life may be lived out in socially useful activities, which have no relationship whatever to the production of something of particular physical, economic value.

We could discuss the gap which is increasing between the haves and the have nots as a result of the manner in which civilized or highly structured society or industrial society is moving. The gap is increasing because the techniques and the understandings and the good will necessary to try to bring about a closing of the gap do not seem to be existent.

Values are undergoing great change. Man now can deliberately create change, plan change; fix his goals, control that process of change, direct its impact, make decisions. He can and he must. He must make decisions: imperative decisions, respecting the manner in which he reacts to change as well as those for whom he is responsible react to change.

Technology has placed in our hands the kind of tools that make obsolete the concept of looking *forward* to a future. Rather, looking *at* the future, seeing what can be and actually planning the critical path to reach it is the fundamental shift in our thinking. *Forward* implies hope and possibility and the dependence upon an evolutionary kind of process. *At* sees it as it *can* be and *how* it can be achieved.

The processes of mathematical models, simulation, and utilization of quantitative data techniques are now part and parcel of our common life. But what has this to do with continuing education?

One is hopelessly out of date in the modern technological world unless he has some appreciation and knowledge of what technology can do for him. Education is a continuing part of the way of life. In the field of business we are beginning to acknowledge this continuing education process as an essential part of the work load from which actual economic good results.

During World War II, or prior to it, we thought of training in business as job training, job methods training, and job relations training. Most people at that time, caught up in the need for preparing people for productivity, thought of education in business at that level.

Now we have come to see that the greatest resource of the economic process is the human resource. And unlike the capital investment resource, unlike the productivity processes resource, unlike the fiscal accounting resource, the human resource is a changing, growing factor. The nurture of the human resource by continuing education is a practical condition of future's orientation. This contrasts with the static thinking of an earlier period.

We are a people who like to have our anchors lowered and fixed for solid, dependable reference. But the American Assembly in discussions of automation point up in their report, "We must accelerate the accelerating rate of change."

The concept of a future's orientation regards these things as open ended, not fixed. The most constant thing in modern society is the fact of change. The very nature of a demand for a future's orientation is a demand for a continuing process of education.

I would like to go on to what I consider another one of the fundamental shifts of our time—the evidence of generic change in the shift from a society dependent upon physical power to a society more and more dependent upon brainpower. It is a shift from a primary dependence upon physical power to a growing dependence upon brainpower.

I would take you back to a statement made by Huston Smith of the philosophy department of MIT. In a meeting on continuing education, he prefaced his remarks by a comment on what he considered the four greatest

changes in the technology of our time. He referred, of course, to the fission of the atom, to space penetration, and to the penetration of the genetic code DNA's discovery. "The other member of the quartet," he said, "is the computer." And of it he said this: "The mind of man and the computer may yet bring about a true mutation in human thought."

He did not attempt to expand on that. He did make the comment, "I guess if we know what a mutation in human thought is, we would have it." I know that there are currents going on which suggest, as Kenneth Boulding indicates in his remarkable little book, "The Meaning of the Twentieth Century," that the broad stream of our time is making a shift out of civilization into postcivilization. The concept is that we are at a point in human history in which generic changes are taking place, and I think the one we are discussing is one of those.

You see it in the field of agriculture. Go back to the year 1862 and the passing of the Morrill Act, when Congress set up the land-grant colleges. For the first time in history a government invested on a broad scale and in a specific manner in the introduction of brainpower into a major industry. Our great affluence in foods and fibers stems from this act.

Perhaps a mutation in human thought occurred when nomadic man discovered that he could stop in one place, plant seeds, get some animals, let those animals breed, and keep them within his corral. Then some enterprising man discovered that this fellow was reaping a little bit more than he needed for himself and his family, and started buying up the surpluses. He formed a village and it became a city. He hired the priests, hired the soldiers, and organized a marketing exchange with the farmer. There was a great shift in civilization at that point. The shift from mechanical power to brainpower which we are beginning to notice is just as fundamental as that. You see it working its way out in business. I refer to the changes taking place in the actual composition of jobs.

Any analysis of this indicates that the shift is toward greater dependence upon knowledge and mental processes and less dependence upon physical brawn or manipulative skill.

We see it in the knowledge explosion. I used to say that there were 500,000 scientific papers per year of a legitimate status; I sat in an audience the other day when a man stated it is 5 million per year.

I called the Widener Library at Harvard and asked a very simple question: "How many new books are you putting on your shelves each working day?" So on the telephone we figured out that in a 255-working-day year they were putting 945 new books on their shelves every working day and putting into dead storage, 253 per day.

It has been reported that the knowledge industry—education, publishing, research, communications, industry information machines, broadcasting—accounts for one-third of the gross national product. This makes the discovery and the distribution of knowledge a \$300 billion business.

Clark Kerr has indicated that the influence on the economy of the rail-

roads in the last half of the last century and what has happened to the sustaining and developing of our economy by the automobile in the first half of this century may well be what is happening now under the aegis of the knowledge industry. It may well be the sparkplug of our economy in coming decades. He did not propose that something new in electronics or in automics would be the stimulating force of the economy but rather this particularly peculiar capacity of man to grow and to develop which is the characteristic force of our time. What is the place of continuing education in this situation?

We could illustrate the shifts in many ways. When I came to IBM 25 years ago with the order to "find out what education can do for business"—Mr. Watson's own words to me—I discovered when I ran a study of the educational status of the corporation that there was one Ph. D. in the company working as an assistant treasurer. A recent count indicated that there are 945 Ph. D.'s and thousands of others of educational status. Do I hear someone say skeptically, "But that's in a very sophisticated industry?"

Let me read you an employment advertisement. It says, "Are you advanced in systems and data processing? Why not become a member of the 'X' Company team, a leader in the electronic data processing field?" Then it goes on almost like the Apostles' Creed: "Rapid expansion of this dynamic national organization has created many new opportunities in systems and programing in the data processing area." Then it lists seven fields here that did not exist 10 years ago.

Am I reading about General Electric or Raytheon or IBM or other advanced industry. Not at all. This is an ad of the J. C. Penney Co., *a leader in the electronic data processing field*. And why not? Thousands of items of merchandise in all kinds of sizes and seasonal applications come from hundreds of producers all over a great grid of the country by rail, by air, by water, and by truck for hundreds of outlets. Low margins of profit, quick turnover require mathematicians and systems engineers in the dry goods business.

One discovers the intellectual areas taking over in a fashion never conceived of before. Of course, to spell out the human effects of this kind of change in this very simple way is a process of superarrogation. We do see such things happening, however. I suppose in your institutions you see the dissolving of the lines between line and staff that have existed since Alexander the Great, the dissolving of the lines between subordinate and superior. New forms of human relations are taking place under this lifting of the intellectual level of the working world.

In business today we have clusters of operations research men and systems engineers supporting the top executive level. They are not managing the company, but the manager of the company depends upon their skills of mind and their evaluations of the data which they produce as major factors in his decisions.

The lines of superior and subordinate are taking different forms in industry. The intellectual qualification of the people is becoming the controlling factor in these relationships.

Further evidence of this kind of shift is found in the change in the character of knowledge itself: from a world based upon empirical, pragmatic processes to one which now is bringing about a centrality of importance and dependence upon theoretical knowledge. The old world, with the invention of steel and the telephone and the radio and the telegraph was a world of cut and fit, trial and error, catch as catch can. Great ingenuity in it? Yes! But it was a mechanical process.

We seldom invent that way now. Occasionally there is a serendipitous outspringing of something as a result of some work of some individual recluse or inventor, but the great body of our technological advance comes about by an intricate and delicate organization of the intellectual process.

Take the illustration that James Bryant Conant tells. In World War I the American Chemical Society wanted to be useful in the war effort. The Secretary said, "Well, come back tomorrow and I'll have my people here to discuss this with you." When they came back on the morrow, Baker had nobody with him and he said, "Well, we've checked into it, gentlemen, and we find we have a chemist in the War Department. If we need you any more we'll let you know." There are 188,000 engineers in the Federal employ today.

Another Conant illustration refers to Thomas A. Edison, talking to President Wilson about the committee they were setting up for the Navy Board. This is the statement from the record. Edison said to the President, "We might have one mathematical fellow in case we have to calculate something out." How far have we come to a time when mathematicians are at a premium.

There is not a person here that doesn't have something of plastics on his person. This came about by the organization of the molecules into theoretical knowledge before it was ever put into extrusion processes. The character of knowledge is changing and the emphasis, of course, is upon intellectual power.

I have a cartoon out of the New Yorker here. It shows a fellow who has seen much better days. He might even have been a psychiatrist. He is unshaven. He has his pipe in his mouth but it isn't burning. He has his hat between his legs as he sits on the sidewalk. There is a mink coat with two beautiful pins under it going by on the corner and he isn't looking. He is too woebegone for even that. The sign on his chest does not say "blind." It says "flunked science."

It's a new world, a terrifying new world. But if we are so terribly dependent upon the mental processes, the process of constant development and upgrading, of cultivation and of irrigation, the course of continuing education must be a lifelong process.

The characteristic institution of the next half-century is not going to be the productive institution as it has been. The central institution of the coming decades, will be the intellectual institution—the "think tank"—the university—the research organization.

But we are shifting, you see. The center of decision is the intellectual center today and will be more so in the future. If that is not an argument for the development of continuing education in any institution, I don't know what is.

I want to say in conclusion that these are only two of many other trends taking place.

Whitehead once remarked that "a great society is one in which men of business think highly of their function." In this context we might adapt Whitehead thus: "A great society is one in which the educated man thinks humanly of his function." Technology does not think humanly. Let us recognize the fact that these wonderful, masterful instruments that dazzle our imaginations are merely instruments.

The computer can take millions of items of data and put them into all kinds of usable forms. The computer can answer the questions your program it to answer, but it cannot answer the question "What are the right questions to ask?" And all of this panoply of marvelous technological development that is creating such changes for good and for ill is like dust and ashes in our hands if all we do is answer the *what* and the *how*. *Why* is a far more important question than what and how.

This is the area of continuing education which in the kind of life we lead too often gets lost. The social scientists do not know the answers to the "why" questions. But any continuing education program that leaves out the "why" is nothing but the rattling of parts.

Some of us who have been deeply involved in the managerial training process believe that there is an economic good created by management itself: it is not just the manipulator of other productive activities: it contributes a plus, an additional good. The whole is more than the sum of its parts. This synergistic effect is being noticed in training and education. Just putting people together. Just assembling employees in a room produces a group but it adds nothing to the quality of the group or individuals in it. However when the educational effort is added both the individual and the group have improved status and consequently improved productivity. This is the synergistic effect of education.

The same effect is noted in the future's orientation posture in management. It adds a dimension over and above the operating effects of a group or company.

Likewise, the ethical influence in the management process adds an additional value to the normal mechanical and operational effects in an organization. Adding the "why" dimension to the "what" and "how" gives meaning to the process and adds a synergistic value to the quantitative values. Here is the challenge to continuing education.

The poets often see things we miss. Edwin Markham stated this in eight very simple lines. He said, "We're blind until we see/That in the human plan/Nothing is worth the making/If it does not make the man./Why build these cities glorious/If man unbuilt goes?/In vain we build the world/Unless the builder also grows."

Discussion

SESSION CHAIRMAN ALDRICH. In any changing activity we all either participate in or at least pay lip service to the importance of research and evaluation. In the process of continuing education, we are particularly concerned with the evaluation of attitude change which may not correlate with the acquisition of knowledge. The technology of the measurement of acquisition of knowledge is so much more advanced than the technology of measures of acquisition or change of attitudes that it is likely to take precedence in our attempt to educate. I wonder if you could indicate if there are any areas in which technology can contribute to a better understanding of the measurement of change in attitudes as contrasted with acquisition of knowledge?

DR. ORTON. That's the question I had come to ask you.

I shouldn't say I can't, but I'm not equipped as of this moment to deal with the question of technological contributions to the measurements of the shift and change in attitudes. But I will take just a second to say that in the practical process of continuing education in any institution, some of the greatest gains are made where the attitudes are dealt with in relation to the actual process going on. Take, for example, a department of multiple spindle drills, where one machine has many drilling spindles. Parts pass under it, it drills holes by the dozens or hundreds. The department was in the doldrums. The manpower supply was high but effectiveness was low. The superintendent of that factory came to me and asked, "Is there anybody in the organization that can do something for us along this line?"

I sent a chap named Bruce Buckler over to look at it. Bruce Buckler was not a machinist. He wasn't a manufacturing executive. Bruce Buckler was a man who had some real skills in the relationship of participation to processes. He asked the members of this department to draw up some instruction sheets for their work, for he noticed their prints and instructions were dog eared, dirty, and worn.

He said, "Now, I'll be back in a few days and I hope you will have a chance between now and then to do something about these terrible looking things that management should have put into shape before this." He was on their side. They did it. He took their sketches and their lists and their orders and he went back to his laboratory of visual aids and put them into nice form, leaving some of the idioms in, but in nice form. He brought them back in cellophane packages. Actually the attitudes changed completely and the department became an example of effectiveness because they participated in a process.

Wasn't it Edward Lindeman who said, "You can take any period of human history and discover that in that period there are certain foci around which the major trends and activities of the period did concentrate." He goes on through several periods. For instance, in the 19th century he said it was acquisition and competition. He said, "In the 20th

century"—and this, he said, at least 35 years ago—"our century will be characterized by participation and coordination."

These are the central foci of our time. And I think attitudes come under the practical handling of the managing institution. Attitudes are what are changed by the participation in the process far more than by lectures or by posters or all of the paraphernalia of Madison Avenue propaganda. Participation is one of the central foci of our time, and in terms of attitudes I offer you what technology can do in practical ways. I've seen this work in so many instances.

CHANGING CONTINUING EDUCATION IN MENTAL HEALTH An NIMH Perspective

Thomas G. Webster, M.D.

Coming to Chicago, the Windy City and the crossroads of the Nation, I was moved to think how much this conference is occurring in a most appropriate setting. I was reminded of winds of change. I was reminded of the crossroads of civilization, where the intermingling of people from different cultures and backgrounds has generated new ideas and advances.

Four winds of change are converging to fan the flame of continuing education in mental health. We hope that this conference will demonstrate that a flame thus fanned will shed more light even while generating heat. The first wind consists of mushrooming new knowledge, rapid technological advances, and accelerating social change. As we have already heard so eloquently from Bert Brown and Dwayne Orton, these changes are political, economic, and human as well as scientific and technical in nature. The trend is not new and is certainly not unique to the mental health field, but its intensity is ever increasing.

The second wind of change is the national mental health effort. Following earlier joint commission studies, national and State legislation, and recent mental health planning projects at State and local levels, we are now at a crucial stage in which mental health manpower is pivotal for following through on the nationwide effort.

The third wind comes from the field of education. Improvements in education place greater emphasis on continuity and individualization of education and on lifetime learning. Not only is it becoming more difficult to cram total training into the formal years of full-time education but efforts to do so produce a poor educational system.

The fourth wind of change is the economic base for continuing education, which base is increasing in both the private and public sectors of the economy. Despite the fact that at the moment both the private economy and

public funding are in the midst of difficult adjustments, the longer range trend has been very encouraging. This increase in economic resources, combined with a gradual increase in available teachers and facilities, augments the feasibility for making continuing education a more significant built-in component of all employment as well as a leisure-time pursuit. Furthermore, economic pressures join with the other influences mentioned to make continuing education more and more a necessity rather than a leisure-time luxury. Universities and service agencies can take a cue from industry. They must give a bigger slice of their total dollar to continuing education if they are to maintain their position, let alone provide new leadership in a changing society.

Mental Health Manpower Trends

As background to changing continuing education in mental health we should review a few facts about mental health manpower.

Figure 1 presents the total manpower pool in the major mental health disciplines 1950 to 1980. Each of the four lines in figure 1 represents one of the four major mental health disciplines. Let us fly against the winds of change for a moment, back to the postwar period. In 1950 there were approximately 10,000 nurses working in mental health settings, 6,000 psychiatrists, 3,000 psychologists with masters or doctoral degrees in work of direct mental health relevance, and 2,000 psychiatric social workers.

Currently, in 1967, there are in the mental health field approximately 22,000 nurses (roughly 3 percent of all registered nurses), 20,000 psychiatrists, 15,000 psychologists (roughly 69 percent of all psychologists), and 13,000 psychiatric social workers (roughly 10 percent of all social welfare workers). Looking to the future we can see in figure 1 that this growth rate is expected to continue and perhaps accelerate.

How does this growth rate compare to other health professions? As you can see in figure 1, during the 5-year period 1960-1965, the major health professions (medicine, dentistry, environmental health, nursing and health research) increased an average of 18 percent. During the same 5-year period the major mental health professions increased 44 percent.

For purposes of continuing education we must ask, where are these people and what are they doing?

Figure 2 presents the four major mental health disciplines by type of organization in which they are principally employed. The figure is based on a 1965 survey of former NIMH-supported trainees. The survey was conducted by the Manpower and Analytic Studies Branch of the NIMH Division of Manpower and Training Programs, the same branch which produced the other data and illustrations used in this presentation today.

While not completely representative of the total population in the four

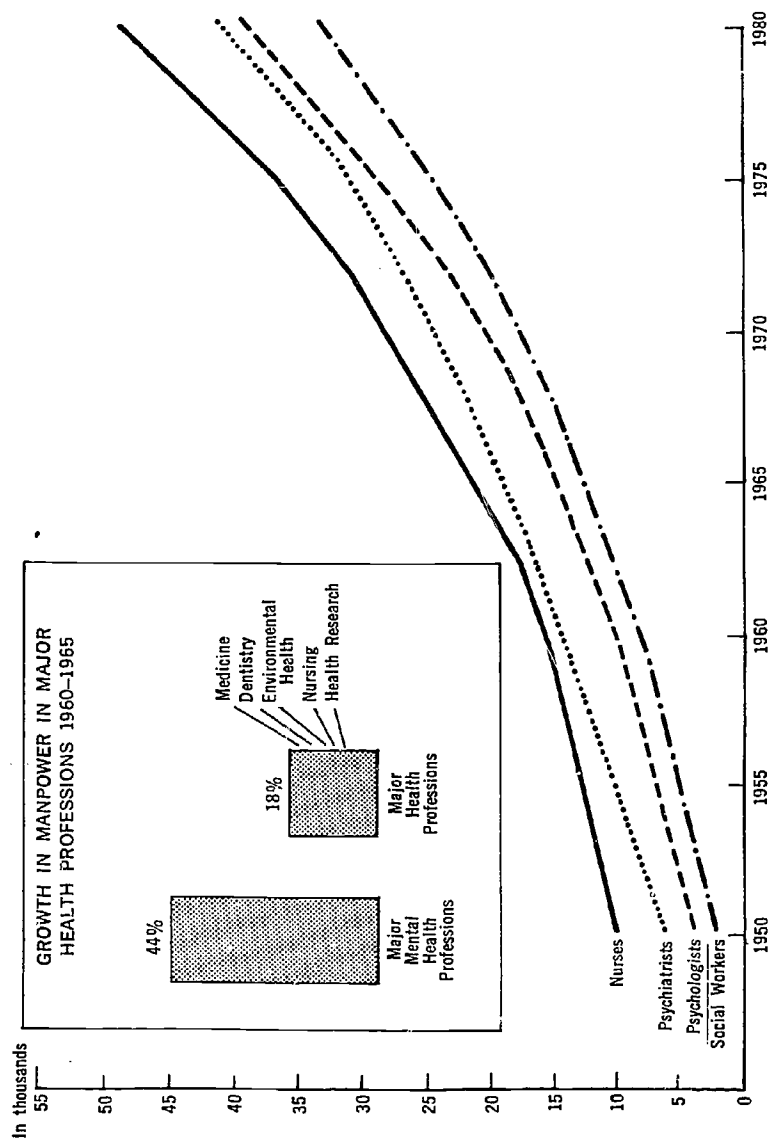


Figure 1.—TOTAL MANPOWER POOL IN MAJOR MENTAL HEALTH DISCIPLINES 1950-1980

mental health disciplines,¹ the figures provide a rough approximation of the total picture. The type of organization in which these persons were principally employed reflects the varying nature of the four professions. For example, the psychiatrists were primarily in private practice (48 percent) or working in a hospital or clinic (35 percent). Psychologists were employed primarily in hospitals and clinics (41 percent) or in academic settings (33 percent). Nurses were also employed primarily in hospitals and clinics (43 percent) or in schools of nursing (35 percent). However, the third largest type of employer of nurses was a health, education, or welfare agency (13 percent), while for psychologists the third largest was a research organization or laboratory (11 percent) and for psychiatrists, medical schools (12 percent). The largest number of social workers were working in hospitals or clinics (46 percent), second was health, education, and welfare agencies (33 percent) and third, academic institutions (8 percent).

The following are issues for your consideration in your small group discussions.

What should be the similarities and differences in continuing education methods, content, and organization for the different disciplines and the different work settings?

- What types of continuing education resources should be developed, and with what priorities, in order to achieve maximal impact in the face of rather infinite need?
- How many employing organizations contribute in financial backing and personnel time?
- What new methods and systems of self-education and mutual education should be utilized?
- What new training and consultation do educators and administrators need in order to develop such methods within organizations?
- What new use of technology, organizational science, and communication systems is required?
- What new reinforcements of motivation for continuing education can be built into career channels and civil service systems?

Moving from work settings to types of activities, how are mental health professions now spending their time?

Figure 3 presents the proportion of time spent in each professional activity. It is, like figure 2, based on a survey of former trainees who were supported by NIMH stipends. Figure 3 presents a picture even more closely related to the task of continuing education. Taken altogether, 45 percent of time is spent in clinical services, and from 9 to 12 percent of time is spent in each of five other activities: teaching, research, administration, consultation, and supervising or training others.

¹ As a group former recipients of NIMH stipends, particularly in social work and nursing, are probably more apt to be in academic positions than are mental health professionals who were not recipients of NIMH stipends.

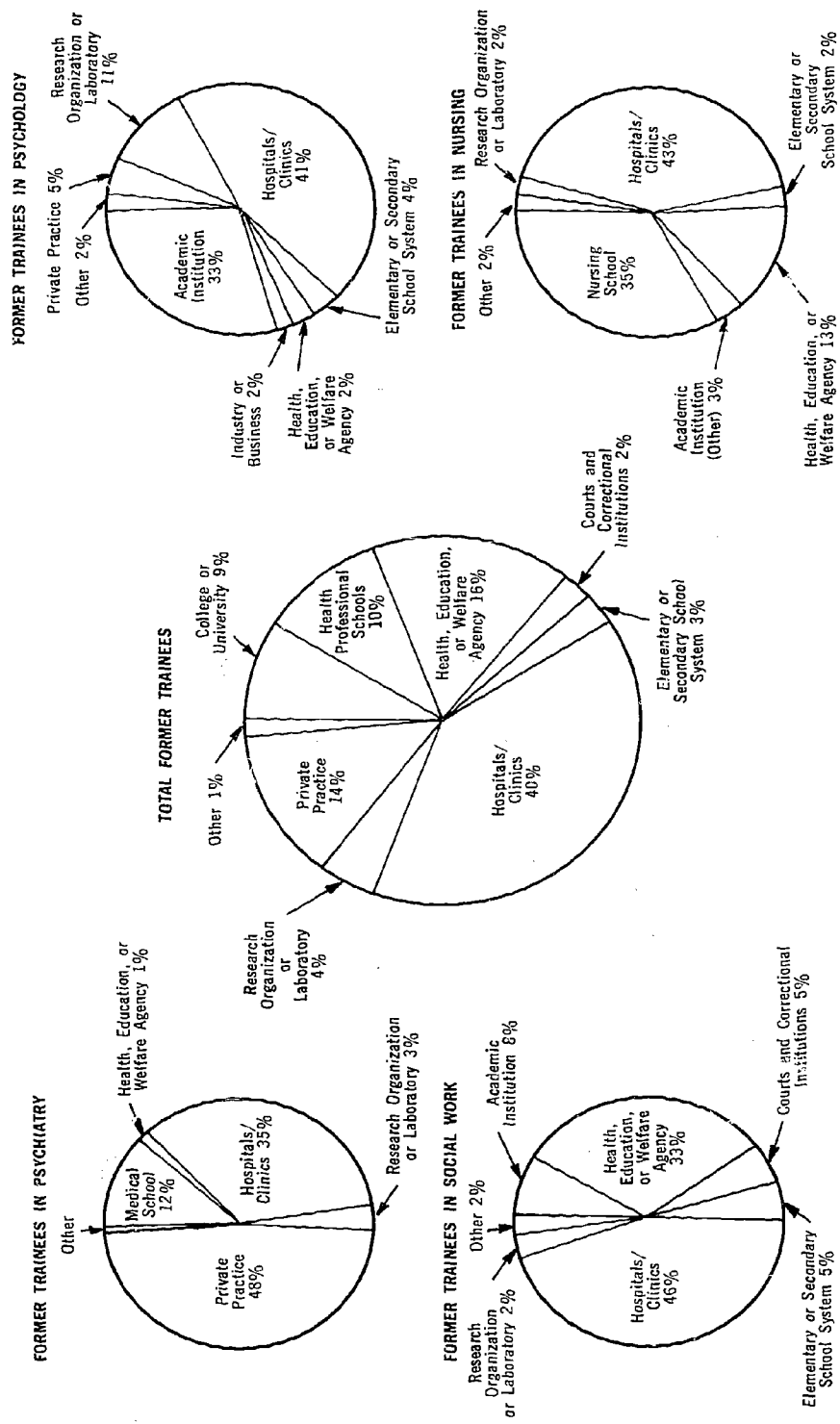


Figure 2.—TYPE OF ORGANIZATION OF PRINCIPAL EMPLOYER 1965

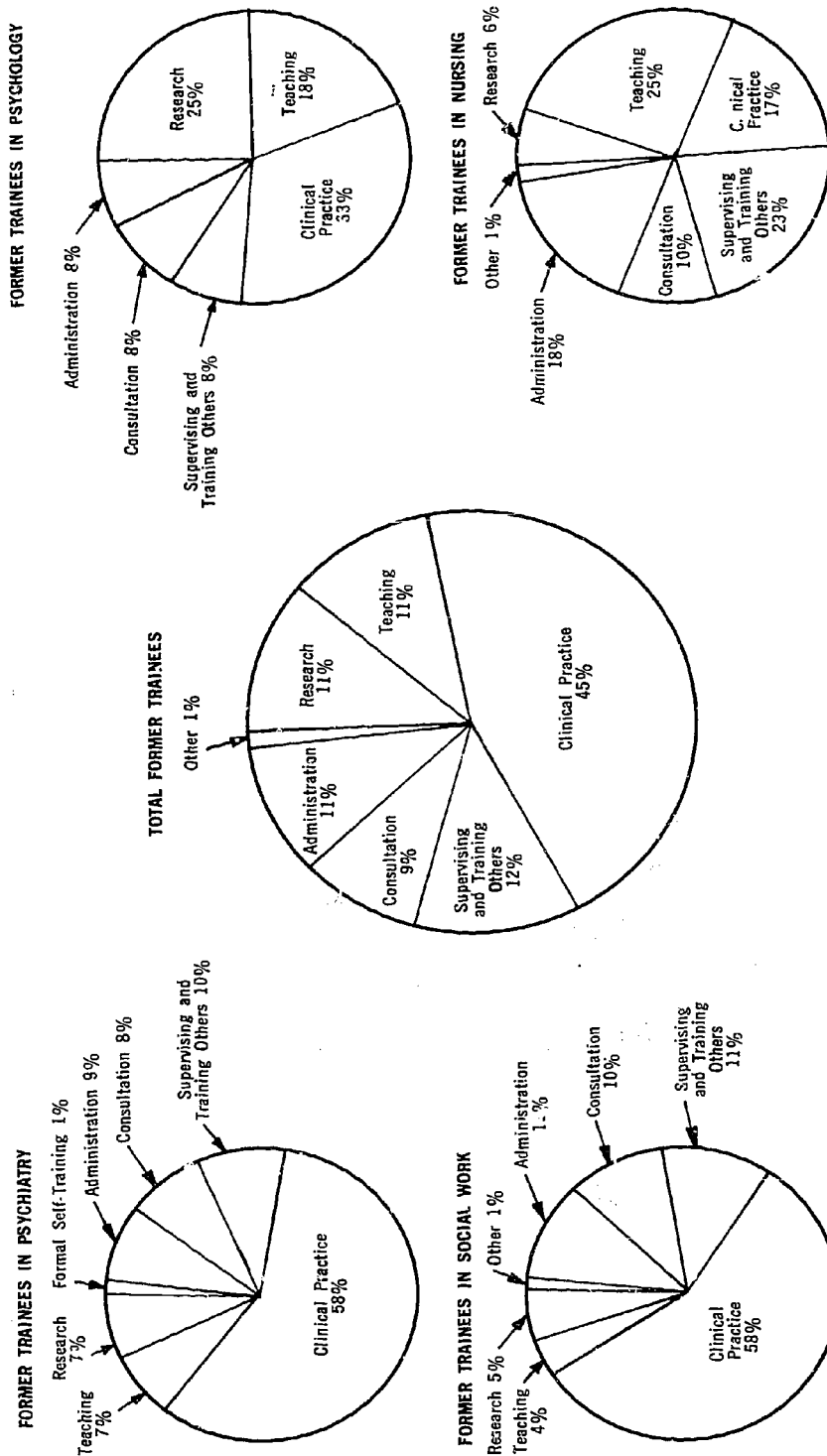


Figure 3.—PROPORTION OF TIME SPENT IN EACH PROFESSIONAL ACTIVITY
1965

Differences in the professions can be noted. For example, psychiatrists and social workers devote relatively large segments of time to direct clinical services. As would be expected, psychologists devote more time to research than do the other three disciplines. Psychiatric nursing is particularly characterized by large proportions of time in administration, consultation, teaching and supervising others.

Support for Mental Health Training: Changing NIMH Emphasis

Let me turn now more specifically to the role of NIMH and legislation. Since its inception in the late 1940's, NIMH has placed emphasis on support of basic training in the mental health professions. The remarkable growth of these professions during the past 20 years is now common knowledge, and you have just seen the evidence in figure 1. It should be noted that NIMH support is only one of several factors producing this growth. For example, an NIMH survey of funding for training of mental health personnel in 1960-1961, revealed that the Federal Government contributed 41 percent, State governments 42 percent, and other sources 17 percent of mental health training funds. There is evidence that NIMH grant programs served as a stimulant rather than a replacement for other types of support.

The soundness of the early NIMH emphasis on basic professional training is self-evident and will continue. Without a large reservoir of highly trained professionals we would not be in a position to meet the challenges of today. At the same time, NIMH and the nationwide mental health effort, have arrived at a new phase of program development. Faced with definite limits in potential recruits, future developments in basic professional training will be comparatively more qualitative, and with greater subspecialty training, even though the growth in numbers will also continue.

Meanwhile the great demand for improved mental health services is now in the public domain, fostered by both citizen and professional groups and concretized by actions of legislatures. Acting under responsibilities to the public and responsibilities for professional leadership the National Institute of Mental Health must promote more efficient and effective use of mental health professionals in the national mental health effort. This implies qualitative changes in basic training programs, greater development of allied professional and so-called nonprofessional personnel, and more active use of continuing education for existing personnel of all types relevant to mental health. From the manpower perspective, these developments imply that basic training and continuing education of mental health professionals will contain a larger component which prepares them to teach, consult, and collaborate with a variety of coworkers who are essential for the delivery of services.

In nursing, for example, we would be closer to an ideal if all nurses in

psychiatric facilities had masters degrees in psychiatric nursing. However, an acute shortage of psychiatric nurses has forced such graduates almost immediately into teaching, administration, consultation, and supervisory responsibilities. Will the present distribution of work in psychiatric nursing be the pattern for the other three disciplines by 1975? You may wish to consider that in your discussion groups.

Regardless of the future patterns of these graphs, there is no question but what a high priority in continuing education for the mental health professions will be to help them extend their expertise to others more effectively through teaching, administration, consultation, and supervision of others. This also implies continuing education to increase their effectiveness as collaborators, coworkers, and participants in programs not identified as "mental health" per se, such as in comprehensive health, industry, crime and delinquency, education and poverty programs. The demands upon mental health professions are increasing, and when they enter such programs they have much to learn in order to make an optimal contribution. Continuing education at the highest level, the kind of thing that Dr. Orton was referring to in part, cannot constitute merely a simple redistribution of mental health professionals dispensing the same kinds of knowledge in the same way to a wider circle of people. The task must be accomplished in new and innovative ways and by more imaginative use of our manpower resources.

Training Funds and Programs

Figure 4 illustrates the dramatic increase in NIMH support of training, including stipends and teaching costs, particularly during the past 10 years. The middle line represents support of basic training of the four major mental health disciplines. The lower line represents the support of other types of training, which has grown at a slightly more rapid rate than basic professional training since 1963. Basic or graduate programs for the four major disciplines now total \$49 million; other types of training total \$47 million. The top line represents the total.

We will now take a closer look at other types of training, the lower line in figure 4. Figure 5 presents the distribution of NIMH training funds which were awarded in program areas other than basic programs, 1948-1967. Note that prior to 1960 all other grant programs were quite small, most of them less than \$1 million. Since 1960 most of them have increased rapidly.

Other types of training are research training (currently \$11 million), including research career development; advanced training in applied practice, and special areas, such as community mental health, forensic psychiatry, geriatric psychiatry, college mental health, school psychology, etc.; undergraduate, including the teaching of psychiatry and behavioral sciences in medical schools; teaching of psychiatry to nonpsychiatric interns and residents; career teacher training for faculty of the mental health professions

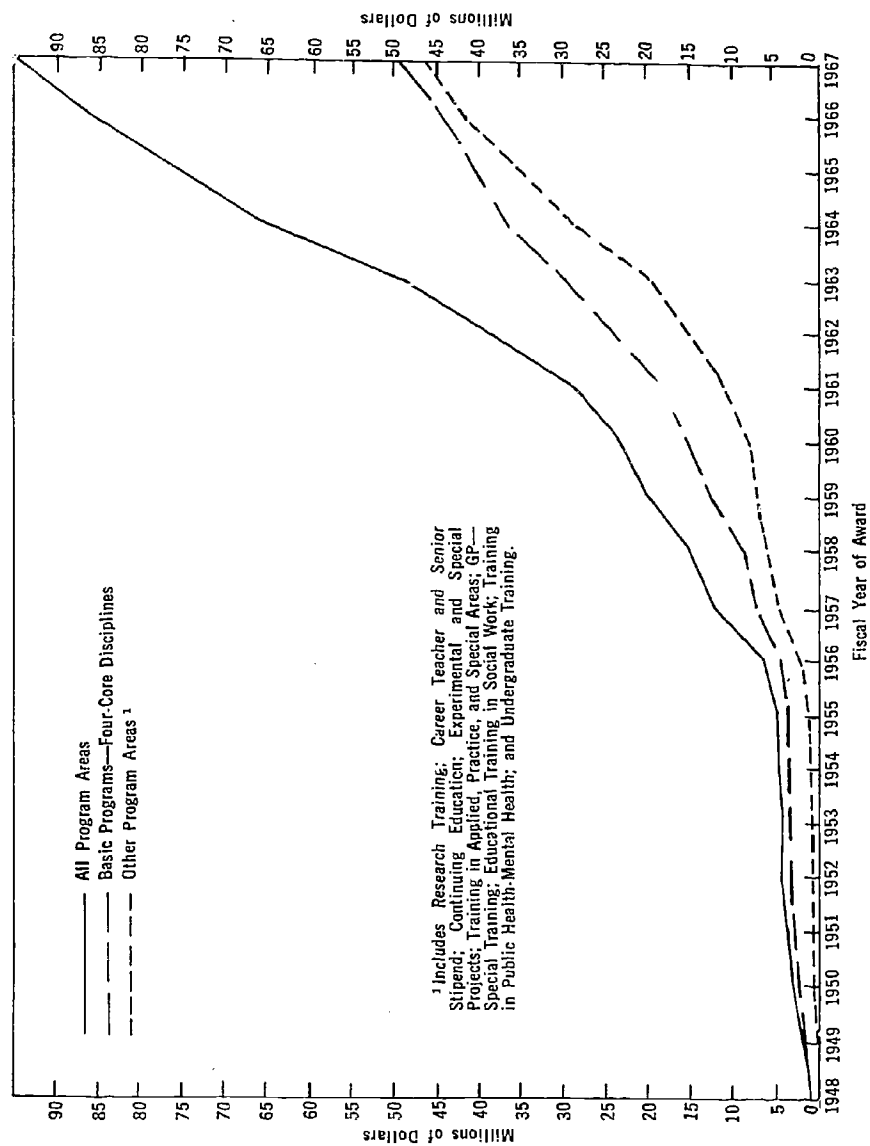


Figure 4.—NIMH TRAINING FUNDS AWARDED, 1948-1967

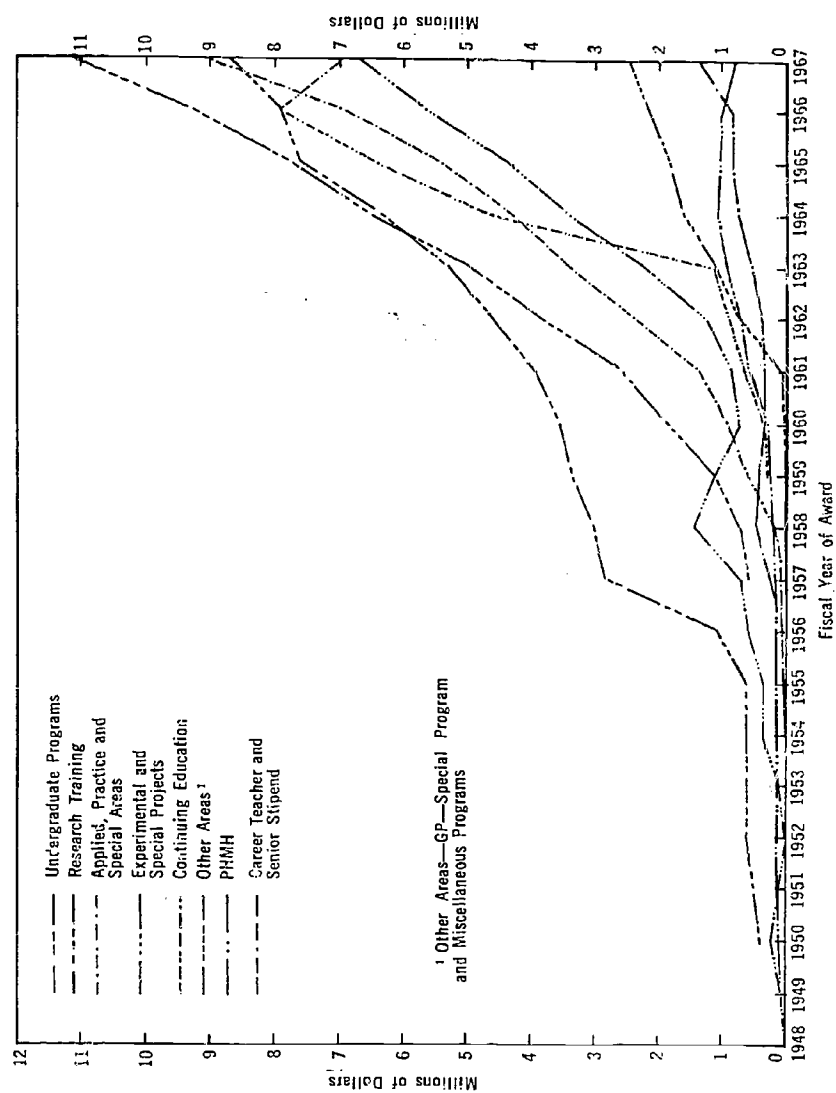


Figure 5.—NIMH TRAINING FUNDS AWARDED IN PROGRAM AREAS OTHER THAN BASIC PROGRAMS, 1948-1967

and senior stipends, which are usually for a year's full-time training of senior faculty; and mental health education in schools of public health.

Another NIMH program, not included in these figures, is the Mental Health Career Development Program for Commissioned Officers in the Public Health Service. This program supports basic training and later supervised field placements for psychiatrists and psychiatric nurses who plan careers in the Public Health Service.

In the grant programs mentioned thus far the training is either a component of basic undergraduate or graduate education or involves relatively formalized full-time subspecialty training of a year or more. Some of the latter are of relevance to continuing education in that issues of professional mid-year development are involved, but these programs are not operationally a part of continuing education so far as NIMH is concerned.

The remaining two grant programs have definite continuing education relevance. Experimental and Special Training Programs, formerly called Pilot Training Programs, have included continuing education projects, such as the staff development program sponsored by the Western Interstate Commission on Higher Education. On the other hand, pilot or experimental programs have also included mental health components of graduate education, such as in theological training, and experimentation in innovative projects in the basic training of the major mental health disciplines. Other types of experimental and special training include new types of mental health personnel, such as mature housewives, volunteers, cottage parents, recreation specialists, junior college mental health technicians, mental health rehabilitation counselors, master's level teachers of emotionally disturbed preschoolers, other child care workers and indigenous nonprofessional community mental health aides from poverty areas. Most of these projects are of an experimental innovative nature and involve full-time basic training of a year or more. However, some consist of part-time, on-the-job training more closely related to continuing education. As an operational definition, full-time basic training—of at least 1-year duration, which prepares persons for new careers—would not be regarded as continuing education. However, an increase in new types of mental health workers has far-reaching implications for continuing education after the workers are on the job, not only for the workers but also for their supervisors and colleagues. Supervisors and colleagues must learn how best and imaginatively to make use of these new kinds of human resources. Revision of civil service systems and other personnel practices are necessary in order to provide new career channels for these new types of mental health personnel as well as to provide continuing education for existing occupations.

The remaining grant program in figure 5 is now titled Continuing Education, though this term was not used until the past year. The line begins in 1959 with the introduction of so-called GP postgraduate education grant support of psychiatric continuing education for all types of practicing physicians other than psychiatrists. In 1963 the curve rises sharply due to

the initiation of so-called Inservice Training grants to State mental hospitals and schools for the retarded. The name of the grant program has recently been changed from Inservice Training to Hospital Staff Development grants. These grants of up to \$25,000 to State institutions have been used primarily for aides and attendants, though some institutions have extended their use to other hospital personnel. During the current year \$4,600,000 of the \$7 million for Continuing Education are for these Inservice Training or Hospital Staff Development grants to State hospitals. The sharp drop in the curve this past year is due to the transfer of Inservice Training grants for State schools for the retarded from NIMH to the Division of Mental Retardation, which is now transferred from the Public Health Service to the newly organized Social and Rehabilitation Service. Except for this transfer of funds there was in the past year actually an increase of Continuing Education grant funds for other purposes.

The Hospital Staff Development grants are currently administered by the Division of Mental Health Services because of their relevance to other State hospital improvement projects. The Division of Mental Health Services also supports Mental Health Program Development Conferences, formerly called Technical Assistance Projects, which provide conferences and workshops for the development of improved mental health services. These conferences, which are not included in figure 5, are mostly for key personnel in State departments of mental health, including hospitals, clinics, and State offices. The conferences are held relatively infrequently for any one group of personnel and are not presumed to fulfill broader and more intensive continuing education needs.

The National Clearinghouse for Mental Health Information is still another NIMH resource for continuing education.

New Directions in NIMH Manpower and Training Programs: Continuing Education Branch

In order to implement the new phase of manpower development, the recent NIMH reorganization included three types of new emphases in mental health training: (1) a new Continuing Education Branch; (2) added emphasis on training innovations and the training of new types of mental health workers via the Experimental and Special Training Branch, and (3) training in special areas of public health significance as part of the new NIMH Centers on Alcoholism, Narcotic and Drug Abuse, Crime and Delinquency, Metropolitan Programs, and Suicide Prevention.

The new Continuing Education Branch was established in July 1966. A new program of grant support for continuing education was extended to include all mental health professions, allied professions, so-called non-professional personnel and citizen groups. An ad hoc advisory committee on continuing education met in October 1966, to discuss basic issues and plans for the expanded continuing education program of the Institute.

Subsequent meetings of advisory grant review committees have provided further policy clarification and guidelines derived from consideration of specific grant project proposals. The present national conference while serving a broader function for the field will be a significant further step in guiding the development of the NIMH continuing education grants program.

Meanwhile, we are not alone. A report of an inventory of federally supported extension and continuing education programs was made to the President's National Advisory Council on Extension and Continuing Education in March 1967. Last spring the Surgeon General of the Public Health Service established an ad hoc committee on continuing education to suggest appropriate measures for more effective collaboration between the many interested agencies within the Public Health Service. The National Institutes of Health regional medical programs have large components of continuing education in heart, stroke, and cancer. The Bureau of Health Manpower, the National Library of Medicine, and other PHS agencies are actively developing basic resources as well as specific projects in continuing education. Many other Federal agencies have similar concerns, and we are pleased to have several of them represented at this conference.

The American Psychiatric Association has established a new office on continuing education for psychiatrists in addition to the older project in continuing education for nonpsychiatric physicians. Other professional organizations, university extension divisions, graduate schools, State departments of mental health, hospitals, and a variety of other agencies are in an active stage of planning new continuing education activities appropriate to their respective functions.

During the past year our Continuing Education Branch staff has been in consultation with many of the agencies and institutions mentioned as well as with experts from universities, industry, and elsewhere. Needless to say, our own continuing education has undergone a growth spurt, and we look forward to this conference as another major source of information and insight.

Priorities of NIMH Continuing Education Grant Programs

During the weeks following announcement of the new NIMH Continuing Education grants program last March (1967), we received over 200 inquiries from the field, and at least that many have been received during subsequent months. Twelve new grant projects were begun last July, and over 50 new grant applications are currently being reviewed. As you know from the newspapers, the 1968 fiscal year appropriation for the Department of Health, Education, and Welfare has not yet been passed by Congress. As you also are aware, prospects for the 1968 domestic budget are not quite as exciting as the manifest interest in the field of continuing education. The major concerns of this conference, however, go far beyond the present year, and the commitments of the Government and the field are clear.

I would like to elaborate on the current priorities of the grants program, give examples of some current grant-supported projects, and in this context point up some relevant issues in the field. One priority is to develop stronger divisions of continuing education in mental health within university extensions, graduate schools, and training centers for the mental health professions. As a field of education, continuing education has characteristically been a part-time and overtime activity of a busy faculty. While there are notable exceptions, support for continuing education has been largely dependent upon registration fees and special grants for specific projects. Often there is not sufficient basic support to provide for administrative staff and faculty for program development, let alone that "think" work of which Dr. Crton speaks. There are notable examples of university extension divisions and graduate schools which have staff devoting full time to the continuing education program, and we are fortunate to have representatives of a few such universities at this conference. Still, continuing education faculties are meager compared to undergraduate and graduate faculties and to the urgent needs of the field. In schools for the mental health professions, and they are not too exceptional as graduate schools go, relatively few faculty members have great experience or knowledge in this type of education. There is a tendency for postgraduate education to be taught very much on the model of graduate courses and seminars or in symposia that resemble conferences and annual meetings of professional groups. This is due both to limitations on faculty time and to limitations in faculty expertise in this type of education. Continuing education is adult education and has many unique features which I trust will be evident throughout this conference. So priority is being given to the development of stronger divisions of continuing education in order to develop more experts and more expertise in the field. Furthermore, the prospect for more adequate continuing education can relieve the burden on undergraduate and graduate programs which are obliged to cram something of everything into basic programs before waving goodbye to their graduates. So the total educational system will be improved thereby.

At the same time service institutions and persons in practice have a much greater role in continuing education than in undergraduate and graduate education. They too must have support for expert leadership in continuing education and for more adequate staff development programs. This implies that employers must be prepared to provide leadership and greater segments of employee time for this purpose.

A second priority is for continuing education to become an integral component in the implementation of community and State mental health planning and program efforts. Educators in university divisions of continuing education should be familiar with such plans as well as with the mental health manpower needs in their vicinity. Their continuing education efforts can thus be targeted where the needs and potential are greatest. By the same token, persons in State mental health departments, hospitals, and other agencies should collaborate with university resources in order to assure

optimal quality in continuing education programs. Unfortunately, at the present stage such agencies are apt to find great limitations in the university resources available. Hence the first priority item mentioned above. One cannot help but feel that the quality of continuing education programs will be improved at both ends by such collaboration.

A third priority is for continuing education projects with a program development emphasis, targeted to the needs of a specific group of potential trainees, rather than isolated courses for whomever may be recruited. Program development implies gathering of data to assess needs and priorities and the ongoing impact of the program of the future. As Dr. Orton described it, to keep very much in touch so that the future is within your grasp rather than a hope. Program development also implies joint planning by trainers and trainees plus the other types of collaboration to which I have referred. Program development implies an awareness of comprehensive health and welfare programs, of which mental health may be only one component.

A fourth priority is research and evaluation. Naturally, research and evaluation should be part of every field of education, but the indications are especially strong in a field so relatively undeveloped as continuing education in mental health. Some of the skills and attitudes most crucial for effective mental health work cannot be learned simply as intellectual knowledge or new technical information. There are always problems in teaching old dogs new tricks, but this is especially true when the task is learning new ways to work with people.

Since continuing education grants are for training rather than research, projects in more formal and sophisticated research would require research grant support rather than continuing education grant support. Fortunately, as far as basic research in continuing education is concerned, we have many allied resources in the projects supported by other Federal agencies and nonfederal sources. Mental health researchers and educators should make a contribution to the general field of continuing education, particularly in such areas as professional identity, interdisciplinary group processes, and motivation for learning. There is also need for collaborative evaluation projects on a national or regional basis, whereby several continuing projects in different settings can be used on a controlled experimental basis for comparative studies which no individual project is in a position to provide. A mechanism must be devised whereby, in selected instances, outside research teams provide objective evaluation of continuing education projects rather than an evaluation made by those responsible for conducting the educational program. At the same time there is also need for guidelines and skills in elementary program analysis which should be a part of every continuing education program. Directors of continuing education programs and their administrative superiors should be provided with appropriate knowledge and skill in program analysis and evaluation as well as other elementary knowledge for effective manpower utilization.

After describing the priorities for continuing education grant support, I

should add an additional note about funding. The need for continuing education, like the need for mental health services, is so vast that NIMH Continuing Education grants cannot provide direct and total support for all that needs to be done. Nor is this programmatically or educationally sound. Some investment by employers and employees in job-related continuing education can help assure the quality and usefulness of this activity. No specific fund matching plan is required, but participation by employers and trainees in planning and funding will increase the priority of continuing education grant applications. At the same time, imaginative use of other sources of funding, such as community mental health center staffing grants and the anticipated increase in grant-in-aid funds to States following comprehensive health planning, may help to make continuing education a built-in component in the development of new services. Mental health planners and administrators should be familiar with other Federal programs, such as regional medical programs, comprehensive health planning, OEO, Department of Labor, rehabilitation, and the Higher Education Act which may conceivably support components in their programs which have relevance for continuing education in mental health.

Examples and Implications in Existing Continuing Education Programs*

The title of my paper, "Changing Continuing Education in Mental Health," is admittedly and intentionally ambiguous. One of the meanings of changing continuing education is that changes are occurring. A second meaning is that directors of continuing education programs are intentionally changing them in order to solve unsolved problems and to meet unmet needs. A third meaning addresses itself to the future. What further changes would we recommend? What are the unsolved problems and which are most capable of solution? What priority should be given to one type of change as compared to another? Once a specific change is given high priority, what is the soundest and most effective way for accomplishing it?

The illustrations and discussion which follow speak to each of the above three meanings of "changing continuing education in mental health," and provide a few examples of answers to the types of questions raised.

Continuing Education for Nonpsychiatric Physicians

Grants in support of continuing education for nonpsychiatric physicians were initiated by NIMH in 1959. While not limited to general practitioners,

*This section was available in mimeographed form at the conference but was omitted from the plenary session presentation. Continuing education grant projects described in this section were selected primarily for purposes of illustrating trends, pointing up issues, and documenting the changes in emphasis of grant projects. Naturally, many worthy and significant projects could not be included in this limited presentation.

the grants have been commonly known as GP postgraduate education grants. This grant program was transferred en bloc from the Psychiatry Training Branch to the new Continuing Education Branch during the past year. Because it is the only such established grant program transferred into the Continuing Education Branch, these grants make up 92 of the 116 continuing education grants now active. As you will see, the 8 years of experience in this type of continuing education has provided a valuable pilot venture from which lessons can be applied to the newer broad-scale continuing education grants program. Keep in mind that physicians, including psychiatrists, are much more apt to be in private practice than are other mental health disciplines. Application of principles and methods from these projects require appropriate modification for other fields, but much is of general interest.

The grants program for nonpsychiatric physicians has grown from 25 grants, \$295,000, in fiscal year 1959 to 92 grants, \$1,223,000 in fiscal year 1967. In fiscal year 1967 the funds were obligated for grants which are active during the current year 1967-1968.

Approximately 10,000 physicians have participated in grant-supported courses as of this date. A recent report of the American Medical Association on medical postgraduate education noted the rapid increase in psychiatric courses in recent years. The number of psychiatric courses for physicians is second only to courses in internal medicine and its subspecialties. A survey of practically all psychiatric postgraduate education courses for nonpsychiatric physicians offered in 1963-1964, including those not supported by NIMH grants, was made by Shriver, Arnhoff, and Robertson, Manpower and Analytic Studies Branch, Division of Manpower and Training Programs, NIMH. The survey revealed that 57 percent of the participants were general practitioners, 13 percent internists, 9 percent pediatricians, and the remainder in lesser proportions from other medical specialties.

The 84 grantees in 1966-1967 included 44 universities and medical colleges; 20 hospitals and clinics; 19 professional societies, academics, and institutes; and one State department of mental health. Seventy-nine of the grants were for direct teaching programs; five grants APA, AAGP, ACP, Pennsylvania AGP, and WICHE were primarily for program development.

While the majority of funded projects are located in areas of population concentration, the GP postgraduate education program reaches many rural and outlying areas where basic professional training programs do not exist. In Connecticut, North Carolina, Michigan, Colorado, Utah, Oregon, and several other States a concerted effort has been made to carry the psychiatric postgraduate education to physicians in all parts of the State. These early efforts are reported to have been very helpful in preparing a more receptive climate for community mental health planning and for the development of community mental health centers. Nonpsychiatric physicians took leadership in areas where psychiatry and mental health programs had previously been relatively alien to physicians. In many instances, the development of a

psychiatric unit in a general hospital had its beginning in such psychiatric postgraduate education efforts. In States such as California and Nebraska many postgraduate education courses are based in State mental hospitals and have brought practicing physicians into more direct contact with such hospitals for the first time. A number of the projects, such as in Massachusetts, New York, North Carolina, Tennessee, and Oregon, have provided physicians with new awareness and occasionally first contacts with psychiatric social workers, public health mental health nurses, probation officers, and other community workers. Some of the projects with the greatest payoff are those based in general hospitals and other community settings where many professional working contacts develop outside the formal educational program.

Teaching methods include lectures, demonstration interviews, closed circuit and educational television, small group discussions, and supervised clinical work. According to the survey of Shriver et al., courses range from a 1-day symposium to over 500 hours of relatively intensive instruction with an average of 31 hours per course and an average of 13 separate sessions per course. Over half are held on a weekly basis. Actual patients are used in approximately half the courses, and case material from the physician's own practice is presented in over 60 percent of the courses. Movies or slides are used in half the courses, audio tape in 35 percent and TV or radio in 11 percent. In 90 percent of the courses the topics most frequently covered include the doctor-patient relationship and emotional components of physical illness.

Experience has clearly shown the importance of gaining the active participation of local medical societies and key nonpsychiatric physicians as co-sponsors of the courses. In several programs, the use of co-instructors, one psychiatrist and one nonpsychiatric physician has proven very effective as a teaching method.

Many of these courses are outgrowths of grant-supported activities of professional organizations. NIMH has supported the programs of the American Psychiatric Association for 7 years and the American Academy of General Practice for 4 years. Collaboration between the two organizations provided a concerted effort in developing various training approaches for general practitioners. An annual APA colloquium and a series of APA-AAGP regional workshops have been held during the past few years. Some recent developments are very encouraging. State chapters of the American Academy of General Practice in Connecticut, Pennsylvania, and Ohio are organizing statewide programs to provide this kind of training. In Suffolk County, N.Y., and in other locations, the Academy and the APA district branch have established courses. A State steering committee on the teaching of psychiatry to nonpsychiatric physicians has been or is being established in each State. Membership includes representatives from the State medical association, State academy of general practice, district branch of the APA, medical schools, and sometimes the State academy of pediatrics. The national and

regional organizations of the APA and AAGP participate in fostering the State programs through the State steering committees.

The American College of Physicians has recently received an NIMH grant (beginning July 1, 1967) to develop more active programs of psychiatric education for internists. The American Academy of Pediatrics, American Academy of Child Psychiatry, and APA currently have a combined task force for developing similar programs to reach pediatricians more effectively.

The Western Interstate Commission for Higher Education and the Southern Regional Educational Board have carried out various kinds of programs aimed at continuing education of physicians and other occupational groups through visitation programs, demonstration courses, institutes and regional conferences. As I have indicated, the APA and AAGP are also organized on a regional basis. I trust that the discussion groups at this conference, particularly in their last two sessions, will have occasion to discuss and suggest additional regional approaches to continuing education and to clarify the appropriate role of professional organizations.

The most common format for postgraduate courses for physicians is a weekly or bimonthly meeting of about 2 hours of a small group for 8 to 12 weeks or even for 1 year. Introductory courses tend to combine lectures with small group discussions. Long-term or advanced courses tend to rely more heavily on small group discussion and case presentations. One- or two-day symposia are still in common usage, particularly as an introductory method for physicians not previously reached. However, more and more the assets and limitations of symposia education have become recognized, and the symposium is seen as only the first step in the educational process. Dr. William Ruhe of the American Medical Association has observed that psychiatric continuing education as compared to other types of medical postgraduate education seems to require more long-range intermittent contact as compared to brief, intensive exposure.

One of the problems which has plagued the field has been the frequent experience that roughly 10 percent of the physicians respond to psychiatric postgraduate course offerings, beyond which recruitment problems become difficult. This 10 percent includes many physicians who are active participants in all types of medical postgraduate education as well as those who have a special interest in psychological aspects of medicine. It also includes a few physicians whose primary concern seems to be the emotional well-being of themselves or their families. The difficulty of reaching beyond the 10 percent appears as much a problem of the educational and recruitment methods as a problem of the potential interest and busy schedule of practitioners. Projects which encounter this difficulty characteristically begin by mailing circulars to the physician population in their vicinity, and recruitment relies heavily on this method. Involvement of key physicians in a community and in professional societies in the planning and conduct of the continuing education program definitely improves recruitment, though this

is no panacea. The following are just two examples of new approaches which have been successful in reaching virtually all physicians in the target groups.

A grant to the Connecticut Academy of General Practice supports a project which is cosponsored by the Connecticut District Branch of the American Psychiatric Association. Responsibility for the educational aspect of the program is borne by Dr. Stephen Fleck of Yale and Dr. Austin McCawley of the Institute of Living in Hartford, representing two of the major psychiatric training centers in the State.

Although utilizing organizational methods more familiar to sales experts than psychiatrists, the project is proving successful in reaching a very high proportion of the target group—general practitioners throughout Connecticut and many other physicians as well. Average attendance is over 80 percent which is quite high for busy practitioners; 83 percent returned for an advanced course.

One lesson that academic persons may well learn from marketing experts, and a lesson that is especially relevant to continuing education, is the importance of understanding the consumer and involving his motivation in the program planning rather than to assume that one is marketing pure gold and that those who do not partake of it are "poorly motivated" or in some other ways not up to snuff. Continuing education has great potentials for reducing some of the town-gown problems which must be solved if all citizens are to receive their fair share of the benefits of scientific advances in the mental health field. The Connecticut project is only one example of the new partnerships between universities, professional associations, and experts from other fields in developing more effective continuing education programs.

The North Carolina Department of Mental Health has sponsored a project that established regular contact with 64 of 68 physicians, essentially all those in active practice, in five Appalachian counties in western North Carolina. Dr. James Cathell, a circuit-riding psychiatrist teacher, traveled from his base in the nearby Broughton State Hospital, seeing physicians in their offices and hospitals with an individualized approach. A side benefit was that a number of public health nurses, social workers and workers in OEO and rehabilitation projects became involved, and physicians learned much more about how to work with such resource persons of whom they were occasionally unaware. While the psychiatrist's primary function was educational, an important element was that he was available by phone at all times, and the State hospital and mental health clinics provided backup services for his teaching efforts.

One of the advantages in working in a specific geographical area and with such a targeted group of potential trainees is that the relation of the educational program to the development of services becomes more tangible and measurable. During the first 2 years of the North Carolina project the admission rate to the State hospital from this five-county area decreased approximately 25 percent, whereas admissions to the same hospital from other surrounding counties was increasing approximately 150 percent. The

general increase in admission rates was due to the development of new mental health clinic services in the area, which is always accompanied by an initial increase in the admission rates to State hospitals. Not only did Dr. Cathell's work seem the primary contributing factor to the decrease in admissions, but by the end of the 2 years Dr. Cathell could almost name the potential hospital patients which were now being managed satisfactorily by the physicians. There were many instances in which crises were averted that under other circumstances would have led to a hospital admission.

Certainly most psychiatrists would not care to undertake such an activity full time, and there would not be sufficient psychiatrists in the county to operate all educational programs in this manner. Questions arose as to how much Dr. Cathell's success was due to a particular individual rather than his method of approach and how much it related to the particular geographic area which he served. Dr. Cathell has now moved to a new base of operations in a more eastern urban area of the State in order to test his methods in a different type of setting. Meanwhile, many of the State mental health clinics and hospitals are successfully utilizing some of their psychiatric staff for consultation and teaching activities similar to those which Dr. Cathell pioneered. It will become an integral part of the State mental health program, supported primarily by the State mental health budget.

One of the issues this project raises is the distinction between consultation services and education. The borderline is not sharp but some distinctions can be made. Dr. Cathell never saw a patient in consultation unless a physician was present. He used the opportunity to teach, following the interview. The aim of an educational approach is for the physician gradually to learn to generalize from the experience rather than to depend on the teacher for the solution of similar problems. Dr. Cathell emphasizes that this takes time. He was repeatedly amazed to find that the physician would not necessarily transfer principles from one case to another where similar principles were involved. However, when reviewed repeatedly and in different contexts, the principles gradually took hold and the physician integrated his learning experience at a level which cannot be accomplished by the customary seminar approaches. This illustrates how the teacher-student work goes through progressive stages, some of which are unique to each student and some of which are quite common to all students.

All teachers of practicing professionals are aware that the initial questions practitioners ask of an educational program is that they get practical and down-to-earth answers to their everyday problems. Here the teaching is more like advice, direct information, and recipes. Sometimes educators with high aspirations are concerned to teach basic principles and mistakenly attempt to bypass this important first stage of continuing education. Their more sophisticated or intellectualizing students find such theoretical principles meaningful or at least intellectually stimulating but the remainder of students must be listed among the "poorly motivated." On the other hand, a consultant or teacher may skillfully speak to this need for practical advice,

but leave the recipient dependent upon the "expert." In such a case, the practitioner does not integrate new functions into his work because the educational process has not advanced to the later stages.

A number of psychiatric instructors in GP postgraduate education projects have described the transitions that have occurred in long-term teaching projects that start with practical patient management issues and which eventually whet the physicians' appetite to understand more of the theoretical principles by which they can generalize their learning. Occasionally, in Dr. Cathell's project, a sufficient number of physicians have arrived at the same stage of learning so that it becomes appropriate to hold a seminar or special group session, perhaps with a visiting expert, to treat a subject in more comprehensive and academic terms. However, such seminars are held only when the timing seems right. Suggested readings can also be handled on a similar basis. Dr. Cathell's approach obviously has great limitations as a solution to all continuing education needs, because of teacher shortages as well as for other reasons. However, every comprehensive continuing education program may do well to have at least one such intensive individualized project in order to keep the continuing educators in tune with some of the deeper issues of the learning process and professional development while carrying out more broad-scale projects which have more limited aims.

A third type of example for reaching more physicians is through imaginative use of radio, television, and television systems. UCLA has developed a closed circuit TV project with two-way communications to reach physicians in the outlying areas surrounding Los Angeles. Physicians meet in their own general hospitals. In Vermont, in Detroit, and elsewhere, educational TV has been utilized. In Vermont this is supplemented by periodic visits to small community hospitals and a 24-hour telephone consultation service that is available to all physicians in the State. In Nebraska and elsewhere closed circuit television is regularly used to connect the medical center with the State hospitals. Such circuits are characteristically used for a variety of purposes, including programs for physicians in the vicinity of the State hospitals. Use of these newer communication systems can be valuable adjuncts to continuing education programs but have great limitations if relied on too exclusively. I have talked with physicians who describe significant numbers of the group falling asleep at the end of a busy day while watching a closed circuit TV program. There are also rapid drops in attendance after the novelty has worn off, if the program is not accompanied by other types of more direct work with the physicians.

The need for teacher training is another issue which has arisen in programs for nonpsychiatric physicians. The WICHE project sponsors annual teacher training sessions for psychiatric instructors. Last year the teacher training focused on child mental health and geriatric psychiatry as well as improved teaching methods. An annual colloquium sponsored by the American Psychiatric Association has been a valuable method for bringing to-

gether teachers and project directors throughout the country and for rapidly disseminating new approaches and research findings in this field of education.

Continuing Education for Mental Health Professionals, Allied Professionals, and Other Mental Health Personnel

Continuing education grants for all types of personnel other than non-psychiatric physicians are at this stage quite new and few in number. Two previously existing grant projects were transferred to the Continuing Education Branch, and the other 12 are new projects which began July 1, 1967. A few examples will be described to give you some idea of their diversity and to point up some general issues which are illustrated in specific grant projects.

Several professional associations, particularly those of the mental health professions, are currently developing plans and some are contemplating continuing education grant applications to extend continuing education in their respective disciplines. The unique and appropriate role of the national professional associations as compared to universities and mental health agencies must be defined within each profession and each association. The same applies to citizen associations, a number of which we are pleased to have represented at this conference. One example is the American Psychiatric Association which established a task force on continuing education for psychiatrists approximately 2 years ago. The task force made a national survey of existing continuing education courses for psychiatrists, which, as might be expected, were relatively few, and surveyed the membership regarding the expressed needs and interests of psychiatrists in continuing education. A new continuing education grant will support an APA staff member to facilitate the work of the task force by fostering program development among the district branches as well as through other channels. Last month Dr. Hugh Carmichael, Professor Emeritus of Psychiatry at the University of Illinois, assumed this staff position at the American Psychiatric Association.

Psychiatric nursing educators have a very large task in providing continuing education to nursing personnel working in mental health settings, many of whom have had little formal training in psychiatric nursing per se. There is another large educational task outside mental health settings for nurses and allied nursing personnel in positions of mental health relevance, such as public health nurses, school nurses, and nurses in general hospitals. A new continuing education grant project at Adelphi University School of Nursing provides extension courses and repeated workshops in psychiatric nursing for all levels of nursing personnel at a number of surrounding institutions and for public health nurses on Long Island.

Many mental health professionals are already in positions of responsibility for community mental health programs. They have little formal training in the special tasks of community mental health compared to their basic

professional training. An example of a metropolitan program to fill this education gap is a project in continuing education in community psychiatry sponsored by the associated faculties program in the Greater Washington, D.C., area. The associated faculties program in community psychiatry is a cooperative project of major teaching institutions and Federal facilities in the Washington metropolitan area. A senior seminar is held monthly on a continuing basis for consultants and teachers in community psychiatry. A 2-year weekly part-time seminar is held for psychiatrists in the Washington-Baltimore area. Most of the participants hold responsible administrative positions, often as directors of psychiatric facilities, and their everyday problems of program development are woven into the educational design. This is an example of a continuing education program which is having an immediate and direct impact on the development of mental health services in the Washington area. Psychiatrists who are classmates in the course are at the same time colleagues in the development of new community mental health services in the Washington area.

The Emory University Department of Psychiatry and the Georgia Mental Health Institute are initiating an interdisciplinary continuing education project in community mental health. The 3-year project plans for graduated program development, beginning with continuing education in community mental health for the faculty and staff of the Georgia Mental Health Institute, which will also be the major faculty in subsequent phases of the program. The Georgia Mental Health Institute is viewed by the Commissioner of Mental Health as the "mental health manpower factory" for the State of Georgia. The project has been planned in close collaboration with the State mental health agency and department of public health, and the continuing education will be closely linked to county public health departments. Several types of continuing education will be available, including periods of full-time intensive training, part-time seminars over a continued period, and on-site consultation-education in the trainees own community. Because public health and mental health programs in Georgia are organized mostly by counties, important target trainees are the county public health officers and public health nurses. Another special target group will be staffs of new community mental health centers as they are established. The project is a good example of collaboration between the university and the State mental health project. One issue that arose in this project was the importance of collaboration between various schools for the mental health professions in such interdisciplinary projects, even in the interdisciplinary setting of a university teaching hospital.

One of the problems in implementing community mental health programs, let alone developing continuing education in community mental health, is the fact that most faculties as well as institutional administrators have had little formal training in community mental health or public health as a component of their basic professional training or as subspecialty training. Fortunately, this educational gap is gradually being filled by new components

in graduate training programs and by subspecialty training in community mental health. Meanwhile, the establishment of many new community mental health centers and the introduction of more community mental health components into basic curricula means that faculty and administrators require continuing education in this field. The two previous projects are examples. A project geared even more specifically to faculty is one which will be conducted in 1968 at the Boston University Department of Psychiatry. A 4-day intensive workshop in community psychiatry for all the departmental faculty, representing all major mental health disciplines, will be conducted by a visiting faculty team from Columbia University. A sociologist will be part of the project in order to evaluate the impact of the workshop on the participant group during and following the workshop.

The California Department of Mental Hygiene sponsors two centers for training in community psychiatry, in Berkeley (Dr. Portia Bell Hume, director) and Los Angeles (Dr. Arnold Beisser, director). Both provide interdisciplinary continuing education in community mental health to large numbers of personnel from State and county institutions and community agencies. A valuable feature of the Berkeley program is that it is organized to fit a variety of individual interests and schedules: part-time courses integrated with supervised field experience during three-quarters of the academic year, full-time intensive training during the summer quarter, or full-time subspecialty training which lasts the entire year. An impressive feature of the Los Angeles program is that the director has spent a great deal of time canvassing and visiting many mental health agencies in his area, so that the educational program could be designed and integrated with the ongoing needs of the individuals and agencies involved.

The Los Angeles County General Hospital psychiatric unit is a good example of a psychiatric facility in transition from a more traditional inpatient unit to a modern community mental health program. It is also a good example of the large municipal general hospitals which are inundated with emergency admissions and a large and rapid turnover of patients from lower socioeconomic groups. Medicare, Medicaid, and the development of the community mental health centers will gradually change this picture, but the old problems still exist in every metropolitan city or county hospital. At Los Angeles County General Hospital, an imaginative program of new services has been initiated, greatly reducing the emphasis on inpatient care while devoting much more staff time to walk-in emergency service, preventing of hospitalization, rapid treatment, and extension of immediate consultation services from the emergency room to the community. Such transitions of an entire psychiatric hospital unit are easier said than done. This particular hospital is at a stage where new ideas are being implemented and the value of a new approach has been demonstrated to the satisfaction of the administrators, but all the staff find themselves involved in new problems of readjustment and morale. Giving up familiar approaches to patient care, in which one has been trained and has developed skill and conviction, in order to take

on new tasks for which one has some skepticism and little specific training is not easy. A new multidisciplinary continuing education project has been initiated for the entire staff in order to facilitate the transition. Learning new concepts and skills is perhaps the easier part of the task. Changes in the institutional social structure, increased turnover in staff during the transition, changes in professional identity, changes in professional values and attitudes, plus intensive factional disputes and interdisciplinary adjustments are all part of the change. At the present stage it remains to be seen what contribution a more concerted effort at continuing education can do to facilitate the many changes throughout the institution.

Examples of new continuing education projects for other types of personnel include a project at Butler Hospital in Providence, R.I., for clergy and educators as well as persons in social agencies and mental health facilities. Consultants from the school of education in the neighboring university assist in the educational design.

The University of Oklahoma Medical Center and Extension Division will hold a 2-week training institute for biostatisticians from State mental health departments. The Southern Regional Education Board has participated in developing such projects for State biostatisticians in the southern region. The institute will be sufficiently individualized and provide for sufficient followup so that the continuing education will be closely geared to the specific responsibilities and differing biostatistical systems which are part of each trainee's ongoing work.

Research and Evaluation of Continuing Education

Current examples are based primarily on the GP postgraduate education program. At the University of Pittsburgh, Dr. Lucy Zabarenko and her associates have engaged in systematic observations, using rating scales for physicians at work in their own offices. Physicians include those taking postgraduate education courses and a control group of physicians not taking courses. This is a longitudinal study which includes observations before, during, and after the postgraduate education courses. A monograph on this research project will be published.

Evaluation studies sponsored by WICHE have utilized sociological methods of research. Judson Pearson, Ph. D., is the director of the research project. A published report of the study may be obtained from the WICHE office in Boulder, Colo.

At the University of Southern California a rather extensive research project by Drs. Allen Enelow, Stephen Abramson, Leta Adler and associates has developed comparative studies of different physician postgraduate groups. The large-scale project utilizes computer methods for comparative studies of changes in attitude. One unique special study by a social scientist of this group concerned a GP postgraduate course which received an unusually poor response from physicians. The same faculty and teaching

methods had had many successes in other settings. The failure to fully appreciate and work through the power structure of the medical community is described in "Desert City: The Ethnography of a Course That Failed."

The Individual, the Organization, and Society: Problems and Potential for Continuing Education

Much of what has been said thus far about continuing education is very much in the context of manpower utilization. However, a precious value in all education focuses on the self-fulfillment of the individual learner. In the manpower perspective, each person is a pair of hands or a set of skills to accomplish the job, whether measured singularly, as a team, or by the thousands. Self-fulfillment and the pursuit of individual interests is the individual's perspective of continuing education, which is not always the same as a place in the manpower pool.

Failure to give adequate attention to this fundamental issue contributes to a more rapid turnover in the staff of an institution as individuals seek to find work in which they can find themselves and fulfill aspirations. The problem is compounded by identity problems of individuals who have difficulty finding themselves in any single position. All this in turn greatly increases the task of continuing education. One of the findings of the WICHE staff development projects for all types of mental health personnel was the large number of trainees who had moved on to other institutions and sometimes to quite different positions within a relatively short time after completing a job-related staff development project.

In spite of all that I have said about the need to relate continuing education to the development of new mental health services I think all persons concerned with manpower problems, whether in a small clinic or a large national program, must keep constantly in mind that individualism is part of the manpower problem and of its solution as well.

Although an educational dilemma exists, these two forces need not be in conflict. Part of the identity task of young individuals and mature adults is to integrate broader social needs into their own self-image. If continuing education does not aid them in this task, it is apt to be inefficient. In this age of rapid social change the identity adjustments of adolescents and young adults must be recapitulated in new contexts roughly four or more times in the working life of each individual. Hopefully, this is an area where continuing educators in mental health can make a contribution to the larger field of continuing education. At present I am not sure that we have distinguished ourselves by our educational solutions to such problems, even though we have done so as therapists of patients and as supervisors of graduate students.

A related problem for both the individual and his work organization is the thwarting of aspirations. The problem is central to motivation for continuing education. One of the most important tasks of adults who keep grow-

ing is successful adjustment to the unfulfilled ideas and aspirations of younger years. Success stories become well known and are an inspiration. But for every success story there are dozens of hidden disappointments. All too often the adjustment has an aftermath of resentment, depression, withdrawal, resignation, and altered motivation. Individuals, teams, and entire organizations get into ruts. Efforts at continuing education can become intellectual entertainment which is more a diversion than a solution to deeper aspirations. At earlier ages and at the extremes such problems lead to school dropouts and many of the familiar problems of poverty. For every individual and organization these problems are to some extent a part of the human condition, facts of life which must be accepted. But I believe much can be done, perhaps more than we imagine at the moment. I trust the conference groups will consider this question: What can be done in the administrative design of work organizations, in personnel practices, and in staff development to help people stay out of ruts?

We are all familiar with the rigidities in organizational structure that are associated with a lack of adaptability to change and with minds that are closed to learning. This is not necessarily cause and effect, but the relationship is clear. Service agencies are under great pressures to produce services. Yet budgets devoted exclusively to services, overattention to the immediate visible production of service, and lack of attention to the individuals and human organization that render the service, can result in rigid hierarchies, resistance to change, and a tendency to hold onto patients or clients for gratification, just as surely as the social structure can result in thwarted aspirations. Overburdened health and welfare facilities characteristically have these problems. In the zeal to produce results, in the long run they may produce less results.

When a rigid hierarchy dominates and pervades the social structure there appears to be a tendency to reinforce human aspirations to rise in the social structure. Inevitably, there are frustrations and reinforcement of power struggles, competition, and discouragement. But people are flexible and gratification of other aspirations may occur quite independently of the hierarchy if suitable alternatives are available, valued, and rewarded by the organization. Such alternative gratifications include creativity, productivity, and learning as well as financial rewards that are not tied exclusively to the formal administrative structure.

not suggesting that changing the table of organization will solve these problems, though it can sometimes help. These are human problems that can only be solved partially by organizational structure alone. I submit that every organization that does not have an active program of continuing education or staff development is increasing the problems of thwarted aspirations and reducing the learning potential and the productivity of the organization, let alone its capacity for change. However, these are not problems which are solved by a seminar or lecture for the staff. The staff develop-

ment program *must be integral to the very fabric of the organization* or it is apt to be an empty intellectual exercise.

Administrators of service agencies are under great pressure to deliver services when clients are knocking at the door and trustees or legislatures review budgets. Carving out time and funds for continuing education of staff may seem like a luxury—and it may *be* a luxury if the continuing education is unimaginative. Those who pay the bill have a responsibility too, and they are most moved by what they call the facts. Perhaps they, too, should have some continuing education as to the facts of manpower utilization and human productivity. But it is up to the continuing educator and the institutional administrator to make the facts available, to relate the educational program to the productivity of a human organization, and to present the case clearly.

Isolation is another factor that is deathly for individuals and organizations which must maintain vitality, optimism, and responsiveness to change. Continuing education programs can be a most significant wedge in the problems of isolation, but education can itself be subject to the same influences. The syndromes of the ivory tower, intellectualism, and the instructor-in-a-rut are well known. So far as adaptation to social change is concerned, continuing education has the handicap of being adult education instead of child education. But as education, it has the great advantage of being an active participant in the outside world, off campus and outside the classroom. This can be the continuing source of its youth, its vigor and its growth. Neither a school nor a service agency can have vitality in isolation.

Let me make one final point about growing pains, changing identity, and changing continuing education in mental health. Historically, the postwar growth of mental health programs, large increases in funding by NIMH and State governments, and the timely attention that has finally been called to the importance of mental health and mental illness—one of society's great unmet needs that had been relegated to the skeleton closet—have tended to command most of the attention of overburdened mental health professionals. New programs to meet other needs, such as poverty and comprehensive health care, much of which has mental health relevance, are now receiving increased funding. Comprehensive health planning will soon be under way just a few years following the initiation of major mental health planning. Regional medical programs for heart, stroke, and cancer have been launched.

The mental health field very much needed and deserved the spotlight of attention and the priority in funding it has received at all levels during the past two decades. The task of implementing new mental health services has only begun, and the enlistment of an even wider range of allied professions and other personnel must continue to expand. Not infrequently we hear concern expressed that we may have overextended ourselves. But our position is not one that any profession can take onto itself; the voice of the public has also been expressed, and it takes the form of new demands and tax support for better services. As we turn our efforts more actively toward

preventive programs we can look forward to becoming an even more integral part of comprehensive health, maternal and child health, the legal and correctional system, public education, the poverty program, labor and industry. At first glance the pressure to integrate mental health programs into larger human service conglomerates appears to be happening too quickly. We already have more problems than our mental health manpower can handle. Yet, perhaps we cannot afford *not* to broaden our efforts and our self-image, just from the standpoint of enlightened self-interest for mental health programs. For a relatively small investment in continuing education and mutual education we can gain some powerful allies in tackling problems that concern us all. Thus, continuing education in mental health may have some identity adjustments of its own to make even while it is at a very young stage of development. Herein is an additional meaning of "changing continuing education in mental health." Herein I believe this conference, with the rich variety of backgrounds represented, is a significant historic occasion.

Second Plenary Session

WEDNESDAY AFTERNOON

OCTOBER 25, 1967

PAUL H. SHEATS, Ph. D.
Session Chairman

DONALD R. McNEIL, Ph. D.*
"The Role of the University"
DISCUSSION

CONTINUING EDUCATION AND COMMUNITY SERVICES: THE CHANGING ROLE OF THE UNIVERSITY

by

Donald R. McNeil, Ph. D.
Chancellor, University Extension
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My thoughts about continuing education, adult education extension, whatever you may call it, as it relates to mental health are certainly my own. But I will say at the outset that this merger of agricultural extension, general extension, and radio and television at the University of Wisconsin, which raised extension to the level of other university units, would not have been possible without the genuine and sincere commitment of the president of the university. And this commitment extends to budget allocation and other responsibilities for strengthening the outreach mechanism of the university. It goes right up and down the line.

Probably the only showdown or near showdown that we had in the matter of cooperative extension service was the matter of who was going to be the director of cooperative extension. As you know, every place in the country had a director of cooperative extension who has had an agricultural background. My being a mere historian did not seem to qualify me to meet the standards of this appointment. There was a protest all the way to Secretary Freeman, and out of it came another example of President Harrington's commitment. We told him what was up, and he said, "No. We're going to insist as a land-grant institution that we can appoint the kind of person we want."

It was proof to me—and I have seen even more in budget sessions—that I do have the commitment of the president. I make this point to emphasize that

*Chancellor McNeil substituted for President Harrington.

while what I am saying to you today represents my own thinking, I'm sure the philosophy behind it would be endorsed by my president.

I read the original letter to the president from Tom Webster asking him to talk on the subject of continuing education in mental health, and Dr. Webster had three points. First, he asked Dr. Harrington to talk about the broad historic perspectives of adult education; second, to talk a little bit about some of the new university extension approaches in continuing education; and, third, to sketch for this group some of the issues, problems, and priorities of continuing education.

Naturally, because I'm not an expert in the field of mental health, I have to confine my remarks to general policy matters, though there may be some illustrative examples of some of our programs that might be applicable.

Let me try to summarize for perspective purposes some of the trends in higher education and some of the reasons for everybody's interest in adult and continuing education.

It is quite obvious that everybody in every profession and every occupation is beginning to realize that new technology has brought the need for whole new groups of skills for which we do not have the talent. We are finding also as we progress in our society that there is a great deal of obsolescence in many fields and occupations. Tied to this, of course, is our profligate waste of talent both in the slums and suburbia. We know that in and out of occupations many of our people certainly have not reached their capacities. We know that among the poor there are millions of people who could fulfill productive jobs in society and that we have not even yet begun to reach these people. This waste of talent and this obsolescence is also relevant to the whole matter of having an informed citizenry in this democracy of ours.

There are all kinds of levels of being informed. Take your own field of mental health. We do know that we need educational programs for the public in the field of mental health but there is great confusion, great misunderstanding about what you people are trying to do.

As people begin to realize that public education in certain selected fields—your own included—is a must, the pressure upon the universities to do some of this kind of work is going to increase.

Everybody talks about the implications of increased leisure time as we shorten the work week; and it is going to be shortened even more, and yet we have not prepared for it. We have gone into spectator sports and television, and only now are we beginning to legislate to create support for public broadcasting in the educational field. We have not designed any good programs, any far-reaching implications to handle the great amounts of leisure time that we are going to have in the next 50 years.

Along with the need for professional education and general adult education, society's major problems are also forces for more university involvement. Universities, for the first time in this interaction between society and the institution, are becoming interested in matters of race and poverty and land-

use management and pollution, mental health, the indigent, the prisoners, the total educational program of the total citizen.

These outside forces are beginning to break through the ivory towers of the university, and their impact comes strongest through certain specified agencies. The first of these, one would have to say, is the Federal Government. The trouble with most universities is that they have followed instead of led. It's been up to the Federal Government to provide the leadership, which it certainly has.

If you look over the "Great Society" legislation, you will find to some degree or other written into every piece of legislation some demand and some money for vocational and adult education or higher education.

Just last week I talked to the people in Secretary Weaver's office in Housing and Urban Development. As this agency moves into the cities, there is a whole array of training programs for all kinds of people involved with solving urban problems which must be done, and the HUD people are going to be coming to the universities to get them done.

The Office of Economic Opportunity, HEW, Labor—all want an extension service. The whole idea is spreading throughout the Federal Government. We now have a National Advisory Council, on which President Harrington serves, along with a couple of other people from the continuing education movement. When they looked at what the Federal Government is doing in continuing education and when they began to add up the totals, it was simply staggering.

Cy Houle has just done a paper in which he says there are 37 separate agencies doing continuing education programs in the U.S. Government. The Department of Defense is just one of the agencies. Millions and millions of dollars are being spent by the Federal Government either for the retraining and continuing education of their own people or for training the people they have to deal with as they implement the policies of their particular agency. Second, while the Federal Government is certainly in the leadership position and universities are too often in the process of reacting instead of telling the Federal Government what is good continuing education, the State governments are now moving in.

In Wisconsin we have programs of continuing education for virtually every State agency: agriculture, conservation, welfare. We have just gotten into the prison movement for the first time to work with custodial officers, and with the inmates themselves. Every State and local agency has some relationship with the university in a teaching way, in our providing some kind of learning situation for them. We are exceptional in that we have a particularly large staff and have a good State commitment to the idea of extension.

The State governments are now taking some kind of a leadership position and the demands from the State governments on the universities are going to be far above those of the Federal Government because they are close

at hand. They know what the issues are, what kind of people have to be trained, what kind of education is needed.

The last group, which you could call professional groups—lawyers, engineers, physicians, nurses, social workers—are also increasingly coming to the university with requests for specialized educational programs.

Beyond that there are the cultural programs, the women's programs and general programs for adults. There is a trend now toward going back and rescuing those people who did not go to college and encouraging them to finish their college work which is going to call for some new approaches to higher education, and it is going to have a great deal to do with continuing education.

In short, there is a growing movement in the United States toward a concept of lifelong learning. Small wonder it is strange that a university should take a young man and a young woman at age 18 and teach them until they are 22, or if they get a master's, until they are 23, or if they get a doctorate, until they are 26, or if they are a physician, until about 33, and then drop them. What we in higher education and continuing education have never been able to understand is why this is so. What makes the universities feel that their responsibility for education only goes so far and then should be taken over by some other agency in society? Why should the student body be restricted to a certain age group with access to a certain place where only certain methods of teaching and learning are followed? It simply does not make sense.

But now the times have caught up with the universities and society is changing so rapidly that the universities will be forced to change, too. Here let me hasten to add that along with this new function of continuing education or extension we at Wisconsin would certainly preserve the ivory tower components of the university. Certainly these institutions must encourage and support certain types of researchers who are not oppressed by the immediate needs of society.

What we are saying is what every institution in the land has said. "We believe in teaching, research, and public service." Yet, many institutions' performances have indicated that they are indeed interested in that order: research primarily, teaching secondarily, and public service after that. Proof comes from their budgets, the level of self-support imposed on extension programs, the way their professors are hired and what they are paid to do, the extension function, and the nature of the reward system. In 99 times out of 100, the public service function, particularly as it is administratively assigned through extension programs, is not keeping pace with the teaching and research function.

Given this traditional view of the university's priorities, it is difficult for many institutions to respond to new pressures for public service and to use new techniques. Take the new media, for example. American institutions of higher education have hardly touched television. In the first place, they

do not know how to use it and they are not willing to learn. There is a traditional hidebound attitude in American universities which holds that "hardware" is gimmickry. Yet we know for a fact that in certain disciplines, to teach certain kinds of subject matter, various media and approaches—television, programed instruction, the tape recorder, playing records back and forth, lecturing by telephone hookup—work better, more efficiently, more economically than the lecture in the 50-minute hour.

We have an experiment in Wisconsin now called AIM. Too bad the educators have to get hold of this, but you have your jargon and they have theirs. AIM stands for Articulated Instructional Media. What it means is that we take and design courses in new ways. We use correspondence; we use tape recorders; we use audiovisual materials; we use television; we use radio. Peripatetic professors are involved, too, sometimes for a few days, sometimes for a few weeks. We export education in all kinds of ways to increase our effectiveness in reaching the off-campus learner who cannot come to the campus for regular sessions. We have an educational telephone network now in Wisconsin and we are getting all of our county agents to install it in the courthouses of the State.

A week ago Monday every county agent in the State participated in a long-distance staff meeting which I conducted from one of our educational telephone network stations in Madison. Not only could I reach all the agents at once; they could also call in with questions and reactions which could be heard by everyone on the hookup.

We are also using a second channel on our State radio network for continuing education. Special receivers in courthouses and hospitals and on university center campuses enable lawyers, doctors, nurses, engineers, social workers, veterinarians—groups of all kinds—to assemble easily for programs which usually originate on the Madison campus. We can work with community beautification people, we can train county board members, we can do all kinds of things through these and other new media at low cost. The major consideration, it seems to me, is to be sure we know what we want to do and then adapt the media to it. And what we do in extension experimentally can be very useful to residence people when they start using media, as they undoubtedly will in the university of the future.

A year ago university extension rented a storefront in the inner core in Milwaukee in which there are 86,000 Negroes. You have been hearing of Father Groppi and his work in the ghetto. We work with Father Groppi's people. We have hired some of his people as neighborhood aides so we know what's going on in that neighborhood. We have a prenatal and a postnatal care program that we demonstrated could be operated out of that storefront, and now the Welfare Department is going to take it over and institutionalize it. Extension program people were the first to go into the schools and get the mothers and the fathers in these ghetto districts to sit down with the school teachers and find out what the problems of the

Negro are—particularly the problems of those Negroes who had come from Alabama and Louisiana as recently as a year ago. This program paid off immeasurably, and now a school board is going to take it over and make it an on-going program. We also get at some of the emotional problems besetting the city of Milwaukee in our public affairs programs. Currently in the works is a television series which will tell the ghetto story like it is.

We are also planning to rent space on the South Side and start working with some of the clergy there. A young Negro is starting that project. It began partly because the Polish people in the South Side of Milwaukee have a collective guilty conscience about a terrible demonstration they once staged against Father Groppi. We are capitalizing on this willingness to try and we are going to move into the south side as a university unit, maybe in a supermarket. I think it's interesting that the riot in Milwaukee in July 1967 started right across the street from the university extension storefront, and our window was the only one in the block that wasn't broken. It means that we reached the people. We listened before we talked, asked for community ideas before suggesting any of our own. What we ultimately came up with was the result of an honest interaction. Right now in American universities there is a big push for more student involvement. Extension has worked on the principle of student involvement for years. We do not design programs without involving our clientele, whether it's your group, a group of housewives, farmers, businessmen, or people in the ghetto.

As the University ceases to be a geographical entity, the campus as we know it will disappear and the continuing education people are going to help make it disappear. We are going to have units all over the cities. We are going to have local libraries; and we will be tied into the local library as a study unit for people. We are going to be offering classes at different hours of the day, different kinds of classes. They are all going to be connected visually and auditorily in the future. We know this. We are just taking the first feeble steps.

The supermarkets and the libraries have gone out to the suburbs and broken up the strong central cores and universities are going to have to do the same thing if they are going to meet the educational needs that will confront us in the next 50 years. Education, learning situations, will be all over your cities and towns. Campuses will literally be coming to you.

A new approach to community development is also a most important factor in the changing university. In too many universities and in too many communities, continuing education is thought of as a process where a professor goes out to a certain town and talks for four or five nights.

In Wisconsin we feel we are accomplishing a lot by working with people, by merely finding out what they want, by designing programs for teachers, for social workers or for whole communities. We do a great deal of this, and it's hard to define because it's a little bit hazy. It's almost a consultation service, but it's a consultation service that no other agency in society will provide. We can provide it and we have the resources to do it.

While we work directly with individuals, groups and communities we also have to step up our efforts to train the people who in turn will train other people: vocational school instructors, people in universities, high schools, elementary schools, and so on. This community development, along with the old continuing education, is probably one of the most significant things that is going to happen in institutions of higher education in the future as extension moves into its proper place in the university structure.

Clark Kerr has just called for an urban grant university, patterned after the land grant university. I agree with him but he doesn't go far enough. He is really only thinking of outreach in terms of undergraduate and graduate education but he does not allow for the extension's approach of mobilizing many university resources in a variety of ways.

Let me on my third point talk a little bit about some of the issues and the priorities as I see them. In the first place, in our efforts to disseminate knowledge to professionals like you we have to keep the tieback to the research function. This is what has made co-op extension great.

Consider the professor in the classroom who just makes his notes out after the Ph. D. and then never changes them. That's why the "publish or perish" controversy really arises, you know, because of those of us who insist that the scholar has to keep going on being a scholar.

We have to keep doing research in extension, too. If we lose that connection with research which is going on in the university, then we are going to lose our validity. Given the nature of extension, we need to be particularly strong in applied research. And we would like to get the people on the resident campuses to make a direct hookup with the extension or outreach mechanism so that we can get the best of the research findings out to the professions. Along with taking specialized research findings out to professionals like you, we also have to maintain a general program. While we contribute to specialization by sharing the resources and the knowledge we have in particular fields and disciplines with practitioners like yourselves, we must also maintain some kind of a general program aimed at destroying specialization and improving the total man.

Thirdly, as I've indicated, we need to work at using new media intelligently and we need to continue looking for new program formats. We could, for example, in the medical field do advanced clinical training by visitation or we could find a good program some place in the country and take people to that.

Fourthly, we need to work at making what we learn from our experience in the field apply to improving graduate and undergraduate instruction. What we report from our experience in the field should also suggest new lines of research. In short, keeping extension and teaching and research in touch has real potential and both extension and residence people should work to develop it.

Increasing Federal and State involvement with extension sets another priority. We are going to have to move much more vigorously in response

to these demands, and we're also going to have to counter with demands of our own. One demand is for flexibility and independence. The university should not become analagous to a gas station, serving any group or agency who comes along and says, "Give me 3 hours of this kind of classroom discussion or 4 hours of that kind of seminar." It must retain the freedom to exercise its competence not only in supplying resources but also in determining what the ideal resources are and how to use them. Such an attitude is not always applauded by many agencies who want to run programs themselves, but it is essential to the university's freedom and effectiveness. The university of the future is going to have all kinds of partnerships: with the Federal Government, with organizations like yours, with individuals. It must insist on terms which make it a full partner.

The most pressing priority is destroying the self-support principle which most American universities have imposed on general extension programs. Our big money-makers in Wisconsin are the medical education program, the engineering program, and our Management Institute. What the principle of self-support does is steer a program off balance by forcing it to focus on clientele groups like yourselves who can pay. There is also a tendency to charge plenty where we can in the hope it will help carry no-yield programs in areas like poverty. We often overcharge those who can afford it in an attempt to get around a system which won't allow us to focus on those who can't afford it. Show me an educational program based on a self-support principle and I'll show you an inadequate total educational program because you simply cannot mount it on the basis of charging the well-off to help the poor. You have to have some kind of financial commitment from the State or Federal Government or developmental funds from your own institution to allow you plenty of lead time to plan and plenty of time to design the program and put it into effect, particularly given our recruitment and retention policies in the university.

Another of our priorities is changing the whole university reward system which I mentioned, along with its implications for extension. Reworking the reward system is particularly important because it is closely related to our recruiting. We do have talent searches in universities, but we often overlook the best talent because it does not come fully covered by academic credentials. The story that UCLA wouldn't give Jascha Heifetz an academic appointment because he didn't have a Ph. D. may be apocryphal. But this one I know is true. Our extension lost a lawyer to the University of Maine because the campus department would not provide him an academic home. All he was good at was going out and training county board members about what a good local pollution ordinance ought to be, and he knew all the legal implications of it, which was precisely what we needed him to know.

In the future we are going to have to use all kinds of people as university professors that these ivory tower people never thought of. Why can't a lawyer, a practicing lawyer who is a specialist in a certain field, teach

something in the legal field without having seven books and 42 articles and a Ph. D. or a J.D? It's insane. Universities simply have to open their eyes—and their credentials-oriented minds—and get off the elitist kick they seem to be on.

Lastly I would like to talk about two other points that concern us in Wisconsin and around the Nation. One is the difficulty universities have in organizing really interdisciplinary programs. I think extension is the one place where it can be done.

I have three deans—they are not deans like counterpart deans on the campus. There is a dean of professional and liberal education, a dean of economic and environmental development, and a dean of human resource development.

I just appointed a task force on health to come up with a plan for what we ought to be doing as a university for all of the health services across the State. On that committee is a physician, a lawyer, a social worker, a nurse, and a sociologist. Here is the interdisciplinary approach at work, and it's an approach we must use. Problems are no longer codified the way the departmental structure of the university is. We must do something about getting mobile and flexible, without getting tangled up in minor jurisdictional squabbles within institutions.

We have to preserve in the university the ability to experiment and the ability, above all, to be wrong or to fail. If we always succeed, then I would guess we are not doing our job properly as a university, but too many people are unwilling to take risks. What we are urging at Wisconsin is that the university set aside some risk capital, that we try some bold, new, and daring programs and try to reach audiences we have never reached before.

It's significant that in the city of Madison all our extension programing for housewives is done on the West Side—the wealthy side—of town. We overlooked the East Side, where the majority of “blue collar” and lower status “white collar” jobholders live. Nobody is paying any attention to these people. Yet they vote, they make judgments, they have to cope with our society, too. Here's an area in which we haven't even begun to experiment.

I am not saying that the university should do all things or be all things to all people, but I think we ought to try some things. We ought to be showing the way so that other agencies can take over and carry the job on from year to year while the university moves to new adventures, new experiments, and new demonstrations.

Above all I would like to stress the importance of these evolving partnerships that we're building now with other institutions of higher education with State and local agencies and with the Federal Government. If we can evolve a partnership that means involvement of both sides and a respect between equals, then we'll have something that no other country has had or probably will have.

Discussion

DR. HERBERT LEIBOWITZ. I'd like to ask that you give us a definition of community development. You indicated that you felt the university has something to offer.

CHANCELLOR MCNEIL. I would pose a broad definition of community development. It ranges all the way from economic development to something we're doing now in Wisconsin called total resource development. What we're trying to do is organize citizen groups to sit down and analyze their community as it is right now—in terms of educational opportunities, economic opportunities, health service, cultural programs, social services, and so forth—determine what changes they want to see, set priorities, and develop a comprehensive plan of action. Developing and carrying out these plans involves almost every discipline in the university. Take my own discipline of history, for example. What does that have to do with community development? Well, one of the things that tourism promotes in northern Wisconsin is capitalization of the area's colorful history which tourists find fascinating. Similarly, there are all kinds of disciplines that can be utilized in different ways to promote the welfare of a given community. So when we are talking about community development, I guess in a sense we are talking about covering just about everything that that citizenry does, how it makes a living, how it spends its leisure time, what its recreational facilities are, and so on.

AN SHEATS. Do you, from the point you just made, also agree that there is a need for a kind of competency and expertise on the part of the extension worker which is not necessarily characteristic of the traditional extension function?

CHANCELLOR MCNEIL. Yes, that's correct. One of our big problems, since the merger, has been to take about 322 people on the county staff—home economics agents, the 4-H agents, the agricultural agents, the forestry agents, educational agents, and so on—who once were linked only with the College of Agriculture and make them conscious of their new responsibility for drawing on all the university's resources. In some instances they did this very well. In fact, agricultural extension had been moving in this direction for a long time. When I first became chancellor I discovered that our best poverty program was run by the agricultural extension service in Milwaukee, where you wouldn't think the "aggies" would be at all. But they certainly were, and they had a splendid program in consumer education. They were working with the county welfare department and the Red Cross and had designed a program they called Project Off for A.D.C. mothers. At last count they had taken over 200 women off the welfare rolls in the city of Milwaukee. This urban program, you remember, came from agricultural extension.

We are going to have to broaden the outlook and the approach of the county agents, I think, but the U.S. Department of Agriculture realizes this and I think they are moving already toward an urbanizing approach.

DR. EUGENE LONG. Have you been able to use the old curriculum designers

and planners, or have you designed any method of teaching new curriculum planning skills for your new articulated teaching program?

CHANCELLOR MCNEIL. No. For our articulated instructional media program we have all kinds involved, particularly technicians. Our biggest problem is to find the people who can teach via this new media. For example, we have a man in Milwaukee who designed a biology course. Well, on the first go-round all he did was to tape record it, then add a bibliography and a few slides that students could use in a portable projector. Well, this isn't quite what we're talking about. We have to find people who will analyze every piece of knowledge that is going into that course and see how it can best be presented to a student sitting in the isolation of his living room 200 miles away. These people are hard to come by. When we find them, we give them some free time, spring them away from their teaching duties and let them design their courses.

DR. HAROLD D. CHOPE. Do you have some specific examples in the field of community mental health you could cite which Wisconsin has done?

CHANCELLOR MCNEIL. No, but I brought an ally along who certainly can, Dr. Victor Howerly of the Social Work Department.

DR. VICTOR I. HOWERY. There are a number of brochures on the Wisconsin program on the table. (Available by writing University of Wisconsin Extension, Madison, Wis.)

Third Plenary Session

Summaries of First and Second
Group Meetings

THURSDAY MORNING

OCTOBER 26, 1967

ELIZABETH KEMBLE, Ph. D.
Session Chairman

COLLATORS' REPORTS

ALLEN ENELOW, M.D., Groups A, B, and C

VICTOR HOWERY, Ph. D., Groups D and F

C. L. WINDER, Ph. D., Groups G, H, and I

PANEL DISCUSSION OF COLLATORS' REPORTS

WERNER BOEHM, D.L.

LOUIS R. MOBLEY

ARTHUR BRAYFIELD, Ph. D.

HOWARD M. KERN, Jr., M.D.

REPORTS OF COLLATORS AND PANELISTS

The conference plan provided for feedback through the general sessions after the second and fourth small group sessions (see page 179). This was done by three collators, who circulated through their assigned discussion groups and met after each small group session with the recorders of the group units. Through discussion and the summaries provided by the recorders, the collators gave the reports to which the panelists and later the audience reacted. In the final plenary session Mr. McGlothlin incorporated the essence of the fifth set of group sessions into his closing summary.

Reports of Collators on First and Second Group Sessions

Allen J. Enelow, M.D.

Groups A, B, and C

In *Group A*, questions were raised such as the changing roles in mental health, the gap between the planners of mental health services and the community leaders, and the underutilization of services by those needing them most. Finally, there seemed to be a general discontent with the lack of definition as to what is mental health, what is mental health care, who does it, who

promotes it, and, lastly and probably most important, do those who need it get it?

In the afternoon they struggled with some educational concepts of the nature and characteristics of learning, which led to the question "Learning for what?" which is, of course, a very important question. At this point, a professor in the group went to the blackboard and proceeded to help them formulate the goals by abstracting everything into a series of outlines under four headings: "Why?" meaning why do we do it. "Who?" meaning who do we offer this to. "What?" meaning what are we going to teach them. And "How?" which has two aspects: How do we fund it and how do we teach it? They're only part way through that, and I presume they're going to go on and try to develop that further.

Group B concerned themselves with evaluation, how to measure the impact of education on adults. After struggling with evaluation—that is, the choice of parameters and measuring those as against setting more global goals and then figuring out how to measure those—it was finally agreed that nobody knew what to evaluate, but that we all ought to do it. There was total agreement that evaluation should be preceded by goal setting. The talk then revolved around teaching methods for adults, such as the involvement of the learner and low manipulation and control as opposed to the education of children.

There was general agreement in *Group B* that extension divisions of universities should bring together the funding sources and the working agencies who want to do the training, and that the agencies and extension division should work in a kind of partnership.

Group C was full of fireworks. Speaking in the idiom of their various disciplines and attempting to communicate, made *Group C* seem to have a different flavor than *A* and *B*. There was some ambiguity at first about how to differentiate education from treatment, and at least one discussant felt there was no reason to try to differentiate.

One group proposed devising evaluation measurements to determine the degree of change in certain areas of social alterations—such as, the number of first grade children who are having difficulties—in a target population in which these outcomes were deliberately sought or, in other words, where the program was deliberately designed to achieve such outcomes. Another person, using the idiom of the engineering profession, said exactly the same thing, only he had inputs, outputs, and grids in his statement. Still another viewpoint was that since there are so many intervening variables, it is difficult to correlate social outcome with a positive or negative effect from continuing education, at least at this point. Others felt that one can measure the effectiveness of an education program through problem solving, or problem reduction I should say, and that seemed to be where it ended.

In summary, then, defining goals and trying to figure out how to determine if they have been reached was the trend in all three groups.

Victor I. Howery, Ph. D.
Groups D and F

I'm not going to identify the contributions from Group D or Group F but will attempt to merge them in a summary that grasps their contributions around a single point with the hope that this kind of organization will be helpful in the movement of the conference towards its goals.

I sense that one of the perplexing questions advanced by both of the groups revolved around how do we motivate and what kind of a state of readiness exists that will lead us to adjudge that there is a clientele for continuing education—are we spinning our wheels in developing educational ventures without any affirmations that they will take? So both groups spent some time talking about motivations for participation in continuing education activities, and I have identified six points related to motivating forces that would generate some enthusiasm for participation, and four that will help to sustain motivation after individuals become participants in an educational venture.

First the group suggested that there are individuals occupying roles and carrying out functional assignments who have a general sense of dissatisfaction or anxiety about the way they are performing their assigned roles and that this in itself will be a motivation for participating in continuing education ventures. Can one deliberately stimulate a sense of dissatisfaction? The group felt that if there was adequate supervision and consultation with members of the staff, a sense of dissatisfaction in a positive way could easily be aroused. If it were an imposed prescription, dissatisfaction with performance might not be the result. People would be dissatisfied with the quality of supervision and consultation.

Second, that professionals do have a general subscription to the mandate of keeping up with their own professions and this in itself is motivating.

Third, that individuals carry assignments which require some skills or improvement of skills that have not been a part of their preservice education, so that the assignments are not central to their professional identity and in consequence they will be motivated towards continuing education. Further, that there are groups of people, such as ministers, law enforcement officers, and teachers, who are drawn toward a supplementation or an enhancement of their own educational background and may be drawn into the field of mental health and, therefore, want mental health education through continuing education routes.

Fourth, that there are problems which arise in communities and are accepted by professional groups as problems relevant to their professional concerns, and that these groups then feel a sense of obligation to prepare themselves for some kind of intervention on behalf of the community with which they identify. So it's a social concern which may well motivate individuals to participate in continuing education.

Fifth, that the professions may well be moving towards building certificate-type programs or statuses which indicate that certain members of the profession have reached out to develop skills and competencies not held by all. They are awarded certificates as indications that they have been participants, and this would be motivating.

Sixth, there is the fact that an organization can be so vital and alive that the general social climate stimulates all to a highest level of competency, to a state of making productive use of daily experiences, and that in the peer relationships, colleague relationships, the general work situation, and the whole climate of intellectual and professional curiosity and inquiry will be a real motivating factor. This is a well-developed, positive bureaucracy.

As to ways of sustaining motivation, first, if participants are involved in planning for educational activities, this will increase their readiness to invest themselves.

Second, if the participants feel that the training ventures or educational activities have a direct focus upon their perceptions of their own needs, their motivation will be sustained.

Third, if the instructors who are selected are identified as individuals who have personal experiences and specialized training directly relevant to the assignments of the trainees, they will wish to join the instructor or teacher.

Fourth, as often as possible, the training activities which are carried directly to the work setting of the trainees will sustain their motivation and indicate a concern.

These last four suggest that the role distinction traditionally associated with being a learner and a teacher needs to be made somewhat fuzzy in continuing education; that the stereotype of a teacher who is doing the giving and the learner who is taking it in needs to be shaded so that the two roles are somewhat merged—that they are joining together in an educational adventure in which the teacher learns from the students, the students learn from the teacher, and the roles are not quite so distinct. This seems to be an important condition to continuing education. Thank you.

C. L. Winder, Ph. D.
Groups G, H, and I.

The approach that I have elected to take as collator is to try to identify some major topics, and under each of these major topics to try to formulate a series of what you might think of as hypotheses or propositions or maybe just hangers for further thinking.

Some of the discussion falls under the heading of philosophy of continuing education. When education is advocated, the objectives should be specified. The need is for concepts such as those of the educated person or the trained person.

Education and selection can be posed as major alternative strategies; for

example, in meeting manpower needs or to achieve other objectives. Selection at the present time seems to compare favorably with education and training because of the low level of effectiveness of the latter.

Educators and trainers have been preoccupied with teaching to the neglect of attempting to understand learning. The issue is between teaching versus learning as a way of conceptualizing the problem. What conditions and emphases yield the best results in a teaching emphasis or a learning emphasis?

There is a concern that an emphasis on teaching techniques and technological aids may further dehumanize the educational process.

There is such a thing as negative education. A person may seek out experiences under the heading of education which simply serve to confirm his beliefs and sustain his practice, however unenlightened these may be.

Another general topic is methods of continuing education. Continuing education seems to have borrowed heavily from the usual concepts of education and teaching and these principles do not seem to be particularly powerful. There is a need for a stronger conceptual base for continuing education.

To the extent that spot lectures and preconceived instructional packages, such as courses that simply move from on campus to off campus, are the methods of continuing education, progress has not been sufficient for the needs. There are suggestions of a good many people here regarding methods which show promise. Some of these are an emphasis on problem solving as the focus and stimulus for learning; a recognition that individual case work, or focus on cases, is useful in building personal interest; that good evaluation and feedback within a program tends to be progressive; and that in continuing education we often find that the peers, colleagues, families, community of the educational target group, want to become involved. If the professional gets involved in continuing education, his wife wants also to be involved, et cetera. Consultation was suggested as a method of education.

There was a considerable amount of discussion about conditions which facilitate or inhibit learning. One of the topical areas under this was motivation and reinforcements by rewards.

There is recognition that the purpose of some learning is to reduce the anxiety associated with professional responsibilities. On the other hand, there may be a loss of motivation when the individual is relatively successful in his practice.

I think many of us feel a desired basis for learning is a self-concept, that the adequate professional is a person who continues to study and to learn.

There is recognition that financial gain can be made the basis for participation in education. The example is teachers for better or for worse.

Public and peer acceptance of continued study is an influence on the continuing education process. Acceptance probably tends to promote, but there can be negative attitudes in those around us which tend to limit participation in further educational experiences. Professionals who are not inclined to seek further education will probably be threatened by programs and suggestions that they would participate in further work of this kind.

Then there was a more philosophical note calling attention to the general problem of fear of change and the threat of change, the existentialist kind of concern with dynamic versus static positions.

Also under the heading of conditions of learning there was concern with the involvement of the potential learner. The point was made that often the educator wants to specify the program without adequate knowledge of the interests of the potential learner.

A further point was that experience tells many of us that participation by professionals in continuing education especially seems to hinge strongly on their involvement in planning and development of their educational program. If learners are involved in planning and revisions of plans, their felt needs become known, their anxieties about participation become explicit, and they are handled, and they accept the role of learner more effectively and the educational experience is relevant to their problems.

There was some mention of the problem of how do you group the learners. Do you group them homogeneously by background, like put all the psychologists together? Do you form teams such as all the staff of a clinic? There are advantages and disadvantages which need to be explored and recognized any way you go at this.

We, too, had discussion of evaluation. My overriding impression was that this particular area is identified as a tough problem. There was a good deal of discussion of methods; suggestions that you measure interaction of student and tutor, that nonparticipant observers are useful evaluators, that student evaluations of their program are useful, and that change in behavior during the educational program is a suitable emphasis in many educational programs.

There was a redefinition of evaluation, putting the emphasis on evaluation as process. Evaluation and feedback within a program are a means of promoting learning and increasing motivation. There was recognition that reinforcement of the learner during the program presumes and assumes evaluation and that that should be explicit rather than intuitive, that is, the basis for evaluation.

There were some somewhat philosophical comments on evaluation, such things as "We're probably inclined to take the easy road; evaluation has to mean more than measurement of retention, evaluation should be related to explicit goals of the education, the course curriculum, the program, and that inevitably evaluation provokes fear and may reduce motivation."

Continuing education tends to produce problems of role definition, standards for practice, job classifications, levels of pay, et cetera. Continuing education is an upsetting process. When training in skills and techniques, which were reserved to a profession or to a group of professions, is offered to others, it gives rise to strain in regard to past institutionalization and role definitions. Then there is the problem of a new phase of institutionalization and role definition.

There was also attention to what seems to be a particularly current problem, namely, the institutionalization of continuing education in mental health organizations, and maybe we're heavily involved in that at the moment.

Finally, one of the groups in particular, I think, made a distinctive contribution; one that probably needs a good deal more attention—I would label this the problem of the varied audience for continuing education. The particular examples in this group were that we want continuing education for professionals but we also need continuing education for such groups as volunteers.

Part of the task in mapping the terrain is to conceptualize the many audiences for continuing education in mental health.

Reaction Panel

Werner W. Boehm, D.L.

I find myself in some problem of either identity crisis or role confusion or whatever you people who judge will call it. My comments, and I assume the comments of my fellow panelists, are entirely unpremeditated, unrehearsed, and unplanned. Any duplication which may occur is due to the fact that all of us are very creative.

What I'm trying to do is twofold. I shall try within the limits of the time allotted to me to identify what in my view are some of the major themes that have been covered, and perhaps to suggest whether here, there, and the other place some of these themes might be developed further.

It seems to me that there are some manifest themes clearly identified and perhaps developed to quite an extent, and others that are more latent and not so well developed and not so clearly identifiable.

One theme that is clear, I think, in both explicit and implicit terms, is change; that education seeks change. What is not so clear perhaps is the direction of change. Is it change in attitudes? Is it change in the development of new knowledge? If it's in the development of new knowledge, is it change in behavior, development, or improvement of skill? Or is it all three? I think we all are clear that it conceivably could be any one of those or all three combined. Perhaps one might add, hopefully, that further discussion might cause us to consider for the practitioners in the mental health professions, whether the third of the possible changes, namely, the development of skill, might not be considered the most important, and what the relationship of the development of skill might be with the development of knowledge and attitudes.

There has also been another theme, barely touched upon and perhaps deserving of more development, and that is the nature of continuing education and the levels of continuing education—continuing education for a

variety of personnel on a variety of levels, professional, subprofessional, volunteers, et cetera. The notion implicit here is that continuing education is education that continues something, that builds on some level that is basic, and that level may be anywhere in the wide range of types of formal education, high school, less than high school, college, post graduate, and so forth.

Another theme which was very thoroughly discussed, apparently by virtually every one of the groups, was the theme of motivation. I am impressed that we spent so much time on motivation. Maybe this is due to the fact that we all come from professions which are concerned with change in attitudes, development of personality, and perhaps increased social function. If you want to infer from what I just said that perhaps we spent more time on motivation than is necessary, this inference is correct.

Another theme is the matter of the process of education and the process of learning. Here I wonder whether we have gone as far as perhaps we may wish to go in the remaining 2 days of this conference.

I am impressed, for instance, that the term curriculum, even though we talk about education and refer to processes of learning and of teaching, has not been mentioned, to my knowledge, in any of the reports we have heard today. Yet we have talked upon one aspect in the triad of curriculum building, namely evaluation.

It might be of some value to consider that evaluation is only one of the elements of curriculum building, and I quickly add that I don't believe that good curriculum is necessarily an effective answer to good teaching. I would say that one can be a good teacher without a good curriculum, although I think it is difficult; but I'm also convinced that one can be a much better teacher with a good curriculum, but a good curriculum in and of itself, of course, does not guarantee good teaching.

I am impressed with the fact that we have not spent as much time, as conceivably we might, with one of the aspects of curriculum building, namely, the identification of objectives. This has been covered in several of the groups, but perhaps not as clearly, explicitly, or thoroughly as might be desirable. What changes do we seek to accomplish? Do we want attitudinal change? Do we want knowledge development? Do we want skill change? Or do we want all three? I think that objectives might be further developed. Another matter is the focus on the learner. If once we are clear about what we want to achieve, what objectives continuing education should have, the question naturally arises what activities should the learner engage in? What are the learning experiences which we in our best judgment seek to help the learner to engage in?

I am impressed with the fact that we have spent much time on the third aspect of curriculum building, namely, evaluation, which is an outgrowth, literally, of what we do by way of objectives and by way of learning experiences. Perhaps one of the problems of evaluation is that we're not

as clear as we might want to become in the course of this conference about desirable educational objectives of continuing education and appropriate learning experiences in keeping with these desirable objectives.

We have also spent some time on methods of teaching. Perhaps more on that might be feasible if time permits. I would, therefore, do no more than second the comments of the last collator, Dr. Winder, who raises the question, whether or not the concepts drawn from learning theories which are applicable to younger learners, late adolescents, and early adults are also appropriate for the learning of young and not so young adults who are the consumers of continuing education. Thank you.

Louis R. Mobley

It's interesting how, as different institutions and organizations encounter the problem and process of education, there is a tendency to reinvent the educational wheel, but this is not all bad, in fact. Indeed we discover nowadays, when the world is changing so rapidly, that some of the most interesting innovations being made in any field, including education, are innovations made by individuals who are not part of that professional field. Perhaps the reason is that they are not burdened by all of the things they know.

One reaction I have thus far is that our professionalism is perhaps getting in our way. I chose purely from random a paragraph from one of the reports that came from a collator, and this in no way is being critical, to illustrate the tendency to reinvent the wheel. I'm quoting from one of the groups: "The potential participants should feel a positive attitude toward continuing education in their social milieu. More specifically, motivation to learning, effectiveness of learning, and acceptance of learning must be conceptualized in the following social context: social or peer relationships in the work situation and in the learning situation."

All of which is great stuff, but as I read that a fifth time I finally recalled what Lyman Bryson said—and I think he was saying the same thing, but he said it somewhat differently—when he reminded us that education is effective only at the time of felt need and clear relevance.

Now let me illustrate an approach to continuing education which is used by a few people in other institutional contexts. I'm referring to some of the things that business and industry have learned about continuing education, having been involved seriously with it since World War II.

If I were to put the point of view of an educational experience most succinctly, I would say in any educational planning or experience for continuing education we might well pause to ask the questions "What's the problem?" and "How can we fix it?" Now let us elaborate it a little. There has developed a rather respectable body of experience in continuing education with respect to problem solving and decision making. Problem solving is simply a question of perceiving what exists in the real life situation. This

is the problem of perception. There are courses in perception that are available, and can be given to anybody at any level of their development, courses like persuasive listening. We even have self-learning programs on these kinds of subjects as well as sophisticated curricula. Secondly, the concern of what ought to be. Now, this is the problem of goal setting. It's a problem of visualizing the future, where facts and figures are helpful but not the whole answer. Goal setting is a creative process. It involves affective values, including personal commitment; and professional education doesn't have a great deal to say about these kinds of affective values. Today they're exploring them very seriously. Now, having defined what is and what ought to be, step three is a very obvious one: note or define the deviation. What's the gap between what is and what ought to be? There are entire courses dealing with the process of perceiving the gap; and we might refer to this area of educational curriculum as systems design, a rather important new concept in society today. And, finally, step four, take action. There's no lack of material, or curriculum, or courses on the process of management or administration.

Having stated these rather homely approaches to the educational process to a group of public school educators, I received a rather interesting reaction from an educator who said, "That's not education. That's life."

Arthur Brayfield, Ph. D.

The reporting this morning and the reporting on the reporting has been so comprehensive and so beautifully done that I couldn't possibly comment as a professional.

I merely want to say that if you people are going to take continuing education seriously, I hope that it will be possible to involve lay and citizen groups very extensively.

The only other comment I would make is this: My experiences the last day-and-a-half have led me to hypothesize that probably the greatest fallout in continuing education, the greatest, the maximum educational benefits, will accrue to those persons who are actively involved in developing the continuation program or programs. It will not necessarily be to those who are the recipients, but it will come to those who are involved.

Howard M. Kern, Jr., M.D.

In looking through all the group discussions I saw no mention of joy or fun or pleasure or delight. One of the discussants did mention intellectual thrill and exuberance and this came closest to what I would like for us to try to think about in education.

I think we have to somehow think of the preventive approach and get further down into the educational process through graduate training and undergraduate training, and probably even earlier than that, to keep from destroying the joy that children do have in learning.

There was one other thing that came up in our group which I think is very important. We do know a great deal about educational theory. At least I'm told this by people who do know. We do know that participation—you heard this over and over again this morning—and involvement and finding out and felt needs and all this is important and, yet, week after week, month after month, we give courses. We design the courses so that they can be evaluated, because if you just let two intelligent people get together and talk about something you can't evaluate it, so it isn't a course, you can't give credit for it, and it's hard to get a grant for it.

Also, we keep falling into these rituals of having groups and having recorders, and having recorders of the recorders, and recorders on the recorders of the recorders, and taking up your time like this, so I'm going to stop.

Fourth Plenary Session

Summaries of Third and Fourth
Group Meetings

FRIDAY MORNING

OCTOBER 27, 1967

HUGH CARMICHAEL, M.D.
Session Chairman

COLLATOR'S REPORTS

VICTOR HOWERY, Ph. D., Groups D and F
C. L. WINDER, Ph. D., Groups G, H, and I
ALLEN ENELOW, M.D., Groups A, B, and C

PANEL DISCUSSION OF COLLATOR'S REPORTS

JULES PAGANO
JOHN B. HOLDEN, Ph. D.
SHEPPARD G. KELLAM, M.D.

Reports of Collators on Third and Fourth Group Sessions

Victor I. Howery, Ph. D.

Groups D and F

I won't be able to report on all of the comments and points touched upon in the two groups. I do want to try to pass on to you some of the thinking that seems to be beginning to be organized that shows the movement of the conference and the way the group is moving toward the conclusions of its discussions.

In one of the groups some of the gentlemen who represent the operating agencies who carry an administrative responsibility for translating social policy into a program of action sketched or traced the developments of their program. As they did so, the group leader was able to introduce a schematic that helped the group identify the learning tasks which were associated with the tracing of these developments. So the group was engaged in identifying learning tasks, of which there were 10. I have indicated a couple of them. For example, in establishing or modifying outpatient departments in the community mental health centers, or modifying the patterns of work of a child guidance clinic and organizing community support for this, one of the tasks was to learn how to work with advisory or citizens' committees. Another example would be learning how to study the dimensions of a community and

then tailoring a program to meet these dimensions or these understandings of a community. Altogether the group has 10, and I'm sure in the proceedings you will capture and be able to see all 10 of them (see page 131).

At the same time they were identifying target groups for continuing education. Group one is identified as the professionals in the headquarters group. Now, this headquarters group may be a regional community mental health center administrative group. It may be a State headquarters. Then the suggestion would be that learning how to work with advisory citizens' committee is something applicable to this group, this headquarters professional group.

The second group is the citizens themselves, the citizens who participate on these advisory committees. Learning how to work with them is not applicable for continuing education, so they are not a target group for this particular learning task. If it were phrased "how to function as an advisory citizens' committee," then it would be applicable.

The third group would be those persons who were associated previously with outpatient departments, child guidance clinics, who are taking on assignments quite different under the new concept of the comprehensive community mental health centers, so working with these groups would be applicable.

Now, this device or schematic for thinking seemed to have great impact as a way of organizing one's thoughts and proceeding in developmental stages towards the task of mounting continuing education programs. I would be assuming that the group, as it carries its deliberations further, will be dealing with the matter of who are the resources that can help to translate this identified learning task into learning activity as such. It will be looking at what kind of cooperative relationships will be developed and answering such questions, "How does one create a state of readiness on the part of the trainees to become full participants in programs that emerge from these kinds of tasks, their identification tasks?"

The other group also looked at target groups. They went at it in a slightly different way and they enunciated some principles. To date I have simply a circle here to start a picture. In one group they identified the core professional specialists. There is a suggestion that all of the mental health specialists, the four core disciplines, have something in common and some differences. Continuing education directed toward core professionals may in some sense make this circle more round and firm and fully packed; but, on the other hand, it may also create spurs. That is, one of the core professional groups, through continuing education, will become equipped to carry on a highly unique function and we, therefore, get a new kind of spur of activity.

These core disciplines will need other groups with which they will be working, the nonpsychiatric group, which might be teachers. The idea being that the teachers in some way are related to the core group, with a common body of knowledge, but in no sense identical; but that as continuing educa-

tion activity is carried to its most fruitful point the nonpsychiatric groups may move further into the circle. On the other hand, where we now have, say, the police related in some way to the core disciplines with some overlap, it may be that continuing education may basically have the function of articulating the related assignment as it pertains to mental health to the police, to the extent that they are no longer active in the same way that core disciplines are but are really contiguous to the core disciplines, ~~as~~ adjacent, but in no way interrelated.

One could say that the point may arise where a group such as the clergy group, through continuing education, will reach a point where they are very close in their identity and functions to that of the core of mental health disciplines.

It is highly possible that, in the eyes of one of the groups, that there will be new mental health specialists who will be developed through continuing education. I don't know exactly how to depict this. But, at any rate, there will be this group that may start out there, but as continuing education develops they will be drawn into first this kind of a relationship, then as continuing education allows for the socialization process and then the professionalization process, we may find that through the route of continuing education we have begun steps towards the development of a new mental health specialist and really end up with five disciplines. Continuing Education may have been the spur in thrust that started this.

Around all of these are citizen groups, groups whose motivations make them attentive and concerned about the efforts of these people whom we have identified as groups carrying functional assignments on behalf of the mental health field, and, therefore, continuing education will be dealing with these community leaders. As these community leaders profit from adventures in continuing education, we can expect all of these groups to coalesce in whatever way each perceives his mission. We can see progress of the kind that all of us keep plugging for.

I hope that I have captured the thoughts of the group. Perhaps this afternoon, if I have made any errors in catching their intent, I can correct it.

They also talked about principles that seem to be emerging in continuing education. One, in some way, challenges some of the statements that were made yesterday. That is, that continuing education is built upon a base of preservice education. There seemed to be some question about whether or not this was a principle in which one wanted to get into a lock-step relationship. They are saying that efforts to maximize interdisciplinary education in the continuing education phase of one's professional growth seem highly important and that we can expect some interdisciplinary kind of understandings and appreciation to occur in the preservice professional education, but it is really when one gets into full professional endeavors that one is really ready and prepared to maximize interdisciplinary team-type efforts. In consequence, the principle was proposed for further study and question: "Should continuing education really try to maximize the interdisciplinary areas?"

Another principle talked about was that of diversity and flexibility in program format. The traditions and format of preserving education are managed. The continuing education programs do not have the same mandate for that kind of management, and so one can get built-in diversity and flexibility in the format and one can build in far greater diversity in the range or learning experiences. The question might be, "Should continuing education really be viewed as holding a potential and promise for innovations in training, for great diversity of learning experiences, for some real breakthroughs in education techniques?"

A third principle that appeared to be emerging was that cooperative activity is highly significant. The decision-making assignment to the faculty of a department of psychiatry in a university is pretty clear. They are influenced by the American Psychiatric Association, but the decision-making authority is located within the faculty of the department of psychiatry. The same would apply to other disciplines.

In continuing education maybe the decision-making authority can be viewed as cooperative. If the trainees themselves could make decisions, the administrative bureaucracy can contribute to the decisions. The educational resources, the technicians, and the scholars may contribute. The profession may contribute. So you get a different kind of cooperative activity between agencies with various educational resources.

Another point was that regional activities, such as that undertaken by WICHE and SREB, hold promise for an input of wisdom different from that which we would find if we have only relationships within a given geographical area, or relationships that are built steadily with only one training resource.

I believe I heard the group say that meritorious ideas find their way through communication channels into such organizations as NIMH, but that some of the functions assigned to NIMH mitigate against a reverse process of communication, and that the NIMH, as a point of national leadership, might well take on an assignment of communicating meritorious ideas back to the field on a far broader basis. That places in their hands, then, some kind of an assignment to identify meritorious ideas, test their merit, and then in some way disseminate these ideas to the field. I hope the group will deal with this to give it further articulation.

C. L. Winder, Ph. D.
Groups G, H, and I

Dr. Howery managed to show a remarkable flexibility in his approach to the problem of being a collator. Your misfortune, I suspect, is that I have fallen into a pejorative pattern and so again I'll present you with my notion of the major topics and some related hypotheses.

The first major topic that I think I discern in the groups is concerned

with the question of who has the responsibility for continuing education programs. And the answer seems to be, as one would expect, that there is a multiple and overlapping set of responsibilities involving the professions, agencies, universities and other educational institutions, and government at various levels. There were some points of emphasis. Mental health agencies and other service agencies that have mental health goals have a fundamental responsibility to arrange for continuing education opportunities. Then there was the notion that several agencies, or even large numbers of agencies, should probably pool their needs and try to arrange with a set of resources or an educational resource to mount the needed programs in the interest of efficiency and prevention of an overlapping of function.

There was a reminder again that when programs are mounted by such venerable institutions as universities, they may very well miss the target of the audience; and a reemphasis again in this area of the responsibility of continuing educationists to take very careful account of the audience needs.

Another major topic was what you might call effective program design. Here there was a suspicion that brief programs are often ineffective; the major exception probably being programs for sophisticated learners who do seem better able to profit from the one-shot, one-day, one-lecture kind of educational experience.

When we move to an education program for people from outside the mental health professions, such as police, clergy, teachers, general practitioners, the opinion was expressed that there is a need for rather extended learning experiences, and, further, that such continuing education programs should often provide for a followup phase.

There was also a discussion that I have titled "Management of Conflict." This should fall into the category of effective program design. The specific topic was sensitivity training. It was apparently assumed that as the number and kinds of people involved in mental health services become more heterogeneous, there may be increasing sources of conflict and tension, and that continuing education opportunities should first be available to all and, secondly, should be in part concerned with the resolution of tension.

A third major topic was practical politics. There is a need to build continuously relationships and communication between citizen leaders and mental health professionals. This is a basic requirement that has some implications for continuing education activities for both groups.

Mental health professionals must learn as well as teach. They need to learn from politicians, citizen leaders, and outside innovators. This is a concept of reciprocal learner-teacher relationship.

Continuing education for citizen leaders is a fundamental responsibility of the mental health professionals. Citizen support must be enlisted for mental health activities.

As we plan to train new types of personnel, we must pay attention to the

attitudes, needs, and responsibilities as well as powers of those who can dictate whether they will be employed or not. So there is a job of practical politicking to insure job opportunities for new types of mental health workers who may be created by continuing education program.

The group very appropriately continues to call our attention to the volunteer groups. Here I want to emphasize two of their points: one is that, traditionally, volunteer groups have supported innovative programs, and this is a continuing need if you look at the total problems of the society. That implies a certain kind of flexibility. The second point is that the volunteer groups are particularly good vehicles to arrange for continuing education for the citizenry.

Then there are two things that I'm not at all sure I read in the reports. Perhaps they simply reflect my rich fantasy life late last evening; but I do believe there was some mention of the very real continuing problem of identifying and strengthening leaders in all these different segments that Dr. Howerly was talking about. The second one of these thin threads is the concern with what is variously known as standards, quality control, and accreditation. This is perhaps an especially knotty problem in the area of continuing education.

Allen J. Enelow, M.D.
Groups A, B, and C

I think there are two things that I would describe as major trends. Even though I may deal with them slightly irreverently, I'll try to fill in with details. The first of these was the rather interesting experience of watching what happened in each of groups A, B, and C when they got past the initial exchange that took place on Wednesday. Of course, I've always been impressed with the fact that you can go away with all kinds of information that you can't evaluate if you have only one exchange.

The other trend is that one knows better how to evaluate what the other fellow says if you listen to him a couple of times. The second trend was one in which initially the accusing finger was pointed at the psychiatrist, perhaps, a little more than was fair in that it seemed to me that it applied just as much to every other group here.

In essence the theme everywhere I went is that roles are changing, that role differentiations are beginning to melt and slide into each other, and that we all have to begin to think in new ways of distributing the responsibilities for what we are doing.

Now I'll particularize. *Group A* continued to develop systematically their chart on the blackboard, first developing the formulation of goals they began on Wednesday. They spent quite a bit of time discussing the new function of mental health professionals as leaders and consultants to other groups, taking full cognizance of the fact that mental health professionals are ill-

prepared for this and that the professional schools are not turning out people who are any better prepared to assume this new role.

One of the proposed answers would be that ongoing supervision such as has been practiced for years in the social work field might very well help in some of the other fields.

That right kind (discipline) of graduate, they pointed out, was not necessary for shifting roles after one gets into a new kind of situation where new demands are made on one because roles shift and blend. And to go on with the same theme in a slightly different area, it was pointed out that an equal fluidity is indicated in the type and locale of continuing education, which has to move out of the ivory tower and into the area where the action is.

Now, for some reason my recorder said that the following was asked to be put into the minutes. I wasn't there so I missed the tone of this, and I'm going to paraphrase it just slightly. This was, "Labor doesn't dig the psychiatrist." This is paraphrased. She didn't write it that way. The psychiatrist should come out of his ivory tower and learn from them what they really need. I give you that quote from group A.

In the afternoon some particular programs in general practitioner's psychiatric continuing education were described. Two in particular were discussed: one, in terms of involving the doctor in a see-it, do-it, teach-it sequence; the other in developing collaboratively with community hospitals.

Then, as always happens, funding came up. How much could one look for from NIMH? Where else one can get funding? Finally, they concluded by discussing the resistance to programs, which they divided into two types: consumer resistance, which I might parenthetically add in general practitioner education is very, very high, and, second, administrator of agency resistance, which I gather is equally high.

Moving on to *Group B*, they also got down to particulars. In fact, one gentleman, as soon as I walked into the room, rolled up his sleeve and went to the blackboard. One statewide proposed program was described there. In that State the department of mental hygiene, hoping to use funding from NIHM, State and agency sources, would function to coordinate local cooperating agencies with all educational resources available to them by putting a coordinator in each of five regional offices under the guidance of a regional advisory committee. This proposed model for a statewide plan was discussed, which led to the difficulties involved in putting together a truly inter-disciplinary training program.

They raised a total of nine questions which are quite pertinent and which will appear when you receive the final proceedings. I'll give you just a few to give you the flavor of it. One, "Will NIMH assume a clearing-house role disseminating information about continuing education in mental health?" This seems to fit one of the things that came up in Vic Hower's discussion. Second, "Will NIMH give consulting help to people who want

to start new programs?" This perhaps is the kind of thing that we might find out when we're about to put the proceedings of this whole workshop together. Third, "Will NIMH coordinate programs?" And fourth, "Will the university be able to propose innovative programs?"

Group C has presented me with an excellent summary which reads as follows: "Continuing education in mental health cannot be divorced from political activity." I sat through part of that discussion and I might say that there were some very striking examples of how this is done, including one which was labeled "A Political Science View of How to Solve a Problem." That was such a beautiful exercise in practical politics that I hope that diagram will get reproduced in the proceedings for this meeting (page 122).

They feel, in *Group C*, that we must identify mental health needs by being on the scene. Programs must be worked out using existing political organizations and using the democratic process through arbitration, compromise, consensus, and developing alliances among power groups. There were quite a few good examples given of how this can and has been done.

Three pervasive ideas ran through the discussion: the goals of continuing education in mental health and training the mental health workers have to be related to diagnosing and treating the mental health needs of a community; second, that the process is essentially political; and, third, that this process can be applied to either a geographical type of community, such as, say, Woodlawn or the State of North Carolina, or an occupational community, such as the psychiatrists or the clinical psychologists.

The discussion became increasingly integrated. The members in the group began to explain to each other the idiom of their fields, and I could watch the communication improving as it went along. Ideas crystallized; and this time, instead of leading to a kind of semantic confusion, it seemed that having viewpoints in different fields tended to crystallize these ideas and make them seem more clear.

I would say, in summary, in all three groups I felt that yesterday was characterized by coming more and more to a kind of resolution of the differences in idiom and in background and toward a coordinated tackling of the problem dealing much more with particulars.

Reaction Panel

Jules Pagano

I think perhaps the conference might lead to talking in a different kind of language about some significant things that all the reports have emphasized. I'd like to take a political language tip from the last reporter and start talking about it in those terms, take away the words "Great Society" and put in some other adjective and see what we come up with.

I think one of the important trends is the question we face throughout this country right now of the credential society. We certainly have ear-

marked this as a major concern of how continuing education might relate to the problem. No longer do we really understand how to educate people to do the job that has to be done, but we are concerned about the educational level that may allow people to continue to do whatever they were supposed to be trained to do.

The second one, I think, is the question of the educational society. Can this society really be an educating society? How do we use the experiences of the work and activities performed in our kind of society effectively? What learning can we get out of experience? How do we evaluate it? How do we legitimize it so it can perform the work that must be done, recognizing limitations of talents, recognizing the task before us as an integrated multi-merit kind of approach.

The third one, I think, is looking at society and talking about the kind of technological society we live in, where the role of science is the great challenging idea of the last part of the 20th century. This has implications for everybody. It means that technological society is probably developing new values for us, and it's going to determine motivation in a different way for all of us regardless of the level we are at. This speaks then, I think, to the question of leadership.

In our society the real problem about leadership communication is something like this: "Now, if there is some way in which we can find the answer together we should try, but it's quite obvious, unless you shared my experience, you can't possibly understand what the real implications of the solution are."

So I think this points to the need of continuing education for developing leadership that's flexible, general. Perhaps here we have to take a look at Secretary Gardner's famous quote, "No one is in charge of the broad questions, no one raises the broad question."

Your conference has put a challenge to continuing education that's in tune with the kinds of challenges that face the total society and that you certainly have articulated quite well in the questions. I would like to end with the question you raised about the role of the Federal Government. That certainly is a dialogue that has to be continued. It's being raised in all areas in our society, in all professional areas, all the activities we're involved in.

It seems to me that a very crucial question has been raised about the total role of the various areas of responsibility, where the resources are, and where they are given bases or opportunity for articulation.

John B. Holden, Ph. D.

I think since we are talking about accreditation in the chicken yard, that in all fairness to the Department of Agriculture I should explain that *graduate school* is the name of a continuation program for the Federal community and that we do not have any money to allocate and we do not have

any degrees to give out. All we are trying to do is to help people continue their education at their own expense, mostly on their own time.

I want to congratulate Dr. Webster on the concept and the operation and expectation of this conference. I am a little concerned as an adult educator because the adult education field is already quite fragmented. In fact, I think we must have at least 15 national groups that are primarily concerned with adult education, and, as I attend this conference, I see the possibility of six or seven more in the field of mental health.

I would like to come back to John Gardner, and I think that the challenge is here. John Gardner said that the most significant thing that has happened in the last 10 years has been the recognition of the essentiality of education and the support of it. One of the most significant things that I have noticed in 10 years—and this doesn't take any great perception on my part—is related to what we are talking about here: the new appreciation of the behavioral sciences in the last 10 years. Ten years ago in the Federal Government sensitivity training was a pretty bad word. But now we are engaged in a seminar in which the top executive officers of the Federal Government, including the Assistant Secretary for HEW, are asking us to conduct a seminar on what behavioral science has that will help them to administer and carry out their jobs.

I don't suppose that we will be able to resolve all of these problems in 3 days, but I think this attempt to tackle a few is quite significant. There are many programs. Someone said the other day we have 37 national programs giving out grants. Actually, I think there are 40.

My next point, relates to the essentiality of cooperation. As I hear the reports, I have a feeling that this group may be "starting all over again." Dr. Howery left out one thing that was mentioned in our group. There are some books that have been written in the field in which we are struggling. I would hope that you would look at what has been done rather than to do it over, because what we need now is not a repetition of A, B, or C, but we need to get to D, E, and F. I think you people have the potential to do this and I hate to see you dissipate your energy going over old ground, rather than uncovering some new ground.

The next thing that I would like to emphasize, two or three of the collators have already mentioned. It relates to fixing responsibility. In the final analysis, I think programs should be coordinated and planned in the local community. The local community develops leadership, and this is our responsibility. After all, the Federal Government responds to the local community needs. If we have the right kind of leadership we can develop and improve the quality of living in a community through cooperation.

I sense that even within the mental health group there is quite a bit of competition. In other words, it seems as if each discipline feels it has the answer, and if everybody else would just cooperate with them, and do what they want them to do, the problems would be solved. I don't think it's quite that simple. We're really going to have to plan together and work together

and I guess we're going to have to find resources. It seems necessary to come to a conference like this to discover resources and to get acquainted with people in your own department, perhaps in your own State.

I find in the Department of Agriculture, the nature of my work cuts across all the agencies. I sometimes am introducing people who are in similar work and have been in the same building for 10 years and may not know the other person. Cooperative planning is essential.

Referring to Dr. Winder's statements about sophisticated people being able to take short courses, I suspect that's right, but I hope the sophisticated people will not spend all of their time becoming more sophisticated and more specialized without relating themselves to the total issues of the community and the life of the individual.

Sheppard G. Kellam, M.D.

I haven't been looking forward with much eagerness to coming up and making these few comments. I think there are a number of reasons for my sudden lack of eagerness to give a public speech.

I can say that I'm very proud to be in group C on the basis of Allen's comments.

I suppose I was asked to participate in the panel because I have been working in the neighborhood and developing a mental health center—which is partly true since we have part of a mental health center. We may never in fact have the rest of it.

I can, I suppose, look at the conference from the vantage point of what the "political" aspects feel like. Are they really political? The process is one of becoming involved with a community, of establishing some kind of priorities in collaboration with a community, of really thinking out what there is in psychiatric theory that we could somehow interpolate and use when we sit in the neighborhoods. There are a lot of problems. And looking around for a "how to" operate is no easy task. It is probably the reason why most of the conference, it seems to me, is having trouble keeping its feet on the ground. I don't know if we've solved anything with this conference. I guess the chairman's comment that we weren't supposed to is a relief.

It seems to me that we've said, essentially, all the general banalities we can think of to say, which are really very relevant. That is, you can not talk about continuing education in the abstract. It has to be related to some degree, to where we are in the field. We are not talking about educating psychiatrists to be cabinetmakers or giving them a sense of fulfillment in their personal lives or somehow improving the sex life of psychologists. We are talking about a very specific problem in the field. We are talking about educating a large section of the field, most of which is represented in the power structure of the field, about where the field is going. It seems to me there are two or three aspects that we have to play with.

We've got a notion about a circumscribed community area that somehow

Adolph Meyer saddled the 20th century with. I think this is what we are beginning to be able to consider doing.

There is also the question, "Well, does epidemiology have anything to say at all about anything? How do we define the patient?"

If you take the office door away and suddenly you don't have that criteria of the guy coming through it, how do you choose who the patients are in the neighborhood? That's a very unhappy kind of a problem. If you've got a target population, young kids, whom we have chosen as the first priority, how do you choose which kids are patients?

There are some tremendously important basic unsolved problems for which we still don't have solutions, but for which we somehow have got to loosen up our structure, our power structure, our training structure, so that we can consider with flexibility some of the solutions. I guess this conference is a way to begin.

How we involve the men who are now chairmen of departments, how we involve those who are directors of analytic institutes, and how we involve other groups which are quite important in value setting and in training, I don't really know.

In group C, Walt Head got up and said, "Look, I'm from the Brookings Institution. We're past masters at taking big shots off into the country and getting them to feel dignity in the role of students in reconsidering problems." So maybe the Brookings Institution has one kind of solution to how we, at least, can get people to reconsider criteria and training.

I know that essentially the job of being a psychiatrist has basic similarities whether it is being a psychiatrist in the therapeutic community setting or in the psychotherapy setting. Essentially, if I had to say what those similarities are, they have something to do with a sense of interpersonal process, of how to see what the person you are talking to feels, what are his needs.

To go and talk to Art Brasier, president of TWO, is not political to my way of thinking. It's not unfamiliar to him either. It's not unfamiliar when you're talking to Saul Alinsky about "what it's like;" when you talk about mass group process or engaging with the neighborhood. One of the lessons we got from Saul when we moved into Woodlawn was that we didn't know beans about engaging with large groups—what big shots might say about a ward. We didn't know anything about community groups, or how you become involved with them.

You can describe this as political, in the sense that it's got to do with masses of people, but it's psychiatric in a sense, too. I can feel some comfort, and Shelly Schiff, my buddy, can feel some comfort, because, you know, you can begin to understand. You look at a minister in a community. He's an important man, and you know that somehow you've got to make it with him, and he's got to work with you, and you've got to make it as partners, except that he owns the turf. It's not like the old ward days when the Doc owned the turf. There are some basic differences. On the other hand, there are these sensitive similarities. Saul taught us the principle of

"hot pursuit." How do you pursue TWO? You don't write them polite letters, it turns out, and say, "We need you." You've got to barge into the delegates' assembly and say, "Look. We've got something important we've got to bring up. We're technicians. We can't work here if we don't get help and permission from the community."

This is the ethos of our neighborhood. I don't know that you would go into Wellesley and talk like that. I know what happened to Eric Lindermann when he didn't talk to the community. He's very willing to describe it. He got tarred and feathered. This almost happened to us in Woodlawn. It happened to the board of education in New York recently with P.S. 201, the model school they put up in Harlem without parent participation.

What is parent participation? I think we have to be careful about the banalities of saying how to work with an advisory committee, or that the whole thing is a political process, or any other kind of phraseologies which somehow imply that you really don't have to get into it and apply some kind of personal investment to this process of engagement. And it helps to be a mental healer. Maybe that's one of the few things that mental health has had, leadership characteristics, to offer other agencies. We're supposed to have, and I think we do have a sense of interpersonal process that goes on among people. It's got something to do with how you engage, how you move in, and how you establish relationships.

I think we can go much farther than that really. I think there are plenty of pieces of psychiatric theory which link the community theory, and we have to learn to look for those links. We've got to ask ourselves questions like where does identity formation take place in the neighborhood? Who maintains it? By what process? We join in a community process, not as a politician, but as a psychiatrist. In my case it was as a mental healer. I don't think there is anything sacrosanct about the role of psychiatry in leading this thing. I think we should start diversification in looking in a variety of places and in developing models. There are plenty of roles that other individuals and other disciplines have learned to play which can help and teach us in the end how problems are solved. How much of what is done in Woodlawn can be translated to what is done for a city? Well, we really don't know. But I know that what I'm suggesting is either the beginning of the end or the end of the beginning.

Projections for the Future

FRIDAY AFTERNOON

OCTOBER 27, 1967

HAROLD L. MCPHEETERS, M.D.
Chairman

WILLIAM J. MCGLOTHLIN
"Where Do We Go From Here"

DISCUSSION

WHERE DO WE GO FROM HERE? A Summary Impression of the Conference and the Future

by
William J. McGlothlin
Vice President, University of Louisville

Over the years, I have had the opportunity of working with a number of professional groups. I have great admiration for people in the professions, and particularly for educators in the professions. They have the most difficult of all educational jobs. They must provide a basic understanding of the concepts and knowledge of a field and, in addition, they must aid the student to apply those concepts and that knowledge to the solution of human problems.

As I think back over the meeting we are now concluding, it seems to me that we have talked about two different kinds of things. One kind has been to define ways of keeping mental health professional persons abreast of new knowledge and new concepts and masters of new methods. The second kind of talk has been concerned with ways of extending mental health services through modifying the competence and attitudes of other professionals, not so-called mental health professionals but other professionals, subprofessionals, and nonprofessionals: other professionals such as general practitioners, clergy, teachers, and so on; subprofessionals, such as aides and attendants; and nonprofessionals, such as parent and other lay groups.

We talked a great deal about modifying general practitioners. We talked somewhat less about these others, but the implication was always there. When I worked with the Pilot and Special Projects Committees of NIMH this was the area in which we enjoyed the greatest freedom and experienced the most fun. We considered how we could help lawyers learn something about mental health, how we could help marriage counselors learn something about mental health in spite of their feeling that they already were pretty competent in that field, and how we could encourage theological

schools that wished to modify their curricula. We worked with a great many groups in the hope that out of these kinds of efforts more sources of advice and assistance would be available to people in need of mental health services.

This effort is really quite unusual because in many fields the professional person tries to make sure that nobody else discovers how he does what he does or how he does not do what he does not do. The primitive medicine man, for example, transmitted knowledge of his magic potions and incantations straight down through the family line. The professionals in the mental health fields are quite aware that they themselves cannot satisfy all the needs and all the demands and, therefore, they are anxious to encourage others to undertake more of the total task. I think this is quite unusual. It fits very well, then, within the field of continuing education. The effort is to extend the competence of other groups into this very broad and very significant field.

Now let's talk more specifically about the conference itself. Its composition, as you have been aware, is an interesting one. We have representatives of the various mental health fields, the big four--the biggest of which, in terms of numbers, is nursing. There are others who are not in the mental health professions, and these include representatives of law, of parents, and so on. We are very grateful to these people for contributing their insights and their feelings of reality to the work of the conference.

With such a varied group I have wondered what kind of expectations we had when we came together in this way. What did we hope would develop out of the interaction of these varied people?

I long ago concluded that a group of this size cannot be creative. The best a group like this can do is to arrive at what is the highest common denominator, at some agreement on feasible courses of action. It can serve as a testing ground for proposals, and can make judgments about the possible support such proposals will elicit.

The conference provided a great deal of information to people who needed the information, so it satisfied that objective in part. Largely, however, I think information was obtained through individual exchanges rather than from any presentations to the group.

One of the great things we accomplished was the appreciation of the difficulties that confront us. If we intended to expand the amount of mental health information, knowledge, and appropriate attitudes through the United States and if we planned to use this conference to establish priorities for that task, we have accomplished less than we had hoped.

As I look back on what we did, my guess is that we felt that one of the things that we could manage best would be the exchange of information among these diverse groups and some acquaintance with their values, their language, their intent and, most important of all, perhaps, the kind of people they are.

What difficulties did we have in doing these kinds of things? There were

several and I hesitate to mention them partly because it sounds as if I am being critical and I don't intend this at all.

Some of the groups were struggling in the quicksand of evaluation. Let me hasten to add that I am not attacking evaluation. Evaluation is an essential part of any kind of activity, particularly a social activity. But it is possible to avoid worrying about the problem, by worrying about the evaluation, before you ever get around to what problem you are going to evaluate. This is what some of the groups were doing that first day. They seemed to be concluding that we should undertake only those programs for which an evaluation scheme could be established. If they had stuck at this point, they would have adopted a fairly dangerous conclusion. There are many things which seem to be useful on a broad scale that I am sure cannot be evaluated with any precision. So the question is not whether you evaluate or not, but whether you get hung up on it before you advance to program planning. In the Tennessee Valley Authority a head of our accounting department tried to persuade us to change the program so that it could be more easily accounted for. This seemed to me to be mixing accounting up with program planning. It is this kind of problem that I think we were struggling with. The significance of a program cannot be determined by ease of evaluation.

I am thinking back about what Dr. Louis Rath, when he was at New York University, said one night. It startled me. He spoke of what creativity is or what it is dependent upon. In his mind, creativity is dependent upon at least two kinds of willingnesses. One is the willingness to be destructive. In other words, if you are going to be creative, you are doing something that is different and overturns something that was before. Unless you have the courage to be destructive it is difficult to be creative. If you do not believe this, go into any city that is in the early stages of urban renewal. You will find acres of land in which the buildings have been torn down, the rats have all moved over to other territory, and there's nothing there at all. Later on the creativity comes and the buildings rise.

The second thing that Dr. Rath suggested, and this is equally difficult, is that you have to be willing to act without being able to foresee all the consequences. Now, this jars us because all of us like to think that we can look down the road and see where the road is going to turn. We cannot. If we imagine that we can puzzle out every possible consequence before we act, we shall never act at all.

A second difficulty was that we had what I call the lure of the negative; that is, there is some obviously good research that shows that very short-term educational activities are not very useful. You can get a lot of people together and get them excited, but the next day it is all gone. It simply fades away. In one group this concept was allowed to shade over into the belief that education itself was inadequate and should be avoided. I found myself resenting that apparent belief. We must make sure that we do not get enamored of the negative, or of saying things cannot be done before we even attempt them.

Some years ago a vice president of Macy's store wrote a book on logic. In it, he points out that he had to discipline himself to respond to proposals positively and favorably rather than to say, "Oh, that can't be done." He had discovered that his automatic first reactions were almost always negative, and he had to learn to respond differently.

To do something means you have to change something. It is usually much easier to do nothing than to do something. This is what I call the lure of the negative.

The third difficulty was that our knowledge of universities is limited. Complaints were made that the response of universities is inappropriate, that they are unwilling to respond to problems, and that they sometimes accept funds and use them for their own purposes. Well, I don't know. It's a little difficult to talk about universities, a university. The difference between my institution and the University of California at Berkeley is not a matter of degree. It is a matter of kind. Even my institution is complex enough to keep anybody from saying "the University of Louisville."

There is a lot of opposition to departmentalization, a lot of feeling that academic departments ought to be discontinued. I do not know what should take their place. It is a little hard to imagine organizing a university around human problems. You would have to reorganize it frequently, perhaps issuing different organization charts morning and afternoon. Departmentalization represents fields of human knowledge, and it has all the disadvantages of any organization. You create sharp boundaries and then you discover the problems do not fit those sharp boundaries, so you have to find some way to get people to cross back and forth. Nevertheless, the department is a valuable asset to universities, and I can assure you it will continue to be the basic organizational unit of the university for some time to come.

I was at the University of Michigan this past spring when they appointed a new president. As far as I could tell nobody noticed except the students who invaded his press conference. I think the reason is that schools and departments at Michigan have so much autonomy that the president is restricted to major policy judgments and ceremonial roles. Instead of increasing centralization in universities, we have consistently decentralized over the past years until the department and school have become virtually the dominant units of administration.

In our institution the names of the faculty who are to be appointed are still presented to the board of trustees for approval, but response is largely routine. The board of trustees asks the president, "Is there anything unusual in this list?" and when he says, "No," approval is almost automatic. The real decision on appointments is made by the department with concurrence of its dean.

The boundaries of the departments of course are being traversed. Where anatomy departments were once solely descriptive of structure of the body,

they have often become cytologists, whose interests are close to those of their colleagues, the physiologists. Chemistry and biology feed into biochemistry and physics and biology into biophysics.

Furthermore, universities are beginning to group activities into institutes or centers by focusing on areas or problems. They are struggling to cross departmental lines. A division of university extension or of continuing education is one of the means to this end. Many institutions in the United States have established centers of urban studies, for example. A center of urban studies cannot be placed in the departmental structure. It is related to the social sciences, to education, to engineering, and to public health. It is intended to merge contributions of various departments and focus on them on an area problem.

It is the same thing that agricultural colleges did when they established agricultural extension services, except that this was to take knowledge from the campus to the farm. When they discovered they did not have enough knowledge to take, they set up agricultural experiment stations as distinct research units. Unfortunately, in most land-grant colleges the agricultural experiment station has little to do with the departments of biology, oddly enough. Often the extension group has little to do with the school of education, even though it uses educational devices all the time.

At the University of Chicago the title of interdepartmental units is different. They are called committees rather than institutes or centers. The term makes them sound ad hoc but I notice that they go on forever. The Committee on Human Relations served as consultants in the Tennessee Valley Authority, making anthropological studies of what was going on within that agency.

Universities are responding therefore, to some of the urgent demands made upon them. To do so, they have established special organizational units to supplement the basic unit of the academic department. And in our concern that the university act in our interest, we must recognize and support the crucial task of the university—to advance theoretical knowledge.

Theoretical knowledge is not theoretical in the vulgar sense of being inapplicable or inappropriate or irrelevant. It is extremely relevant because it can be applied to hundreds of different situations rather than to a single one.

Also, we are diffident about knowledge of the processes of education. I was in one group in which the leader responded so vigorously to statements that we know nothing about adult learning that he put a bibliography on the blackboard. He was kind enough to limit this to three books. There is a good deal known about how adults learn, and these three books were only part of the bibliography that you would have to explore if you were going to find out about how adults learn.

Let me suggest that as you develop your interest and concern with con-

tinuing education you investigate the bibliography related to that field just as you would investigate the bibliography related to any other field in which you are interested. These are small cavils. They are part of the reason for having the meeting: to give you an opportunity to understand what is necessary and needed in the various fields.

Let me talk now about achievements. As I wandered around silently I was struck by several significant achievements. Although we were feeling our way the first day, we gradually developed a good deal of momentum and we began to draw charts on the board and to relate to various kinds of knowledge that we had.

The first thing that struck me was that out of all this welter of activity began to emerge a definition of the purpose of what we were doing as change in behavior—not knowledge, not information, not happiness, not joy, not credits, but as actual change of behavior. It seemed to me that this was one of the real achievements of this Conference. I think it may be easier in a mental health group than it is in some other group, but it is significant that we were willing to look for possible evidences of change of behavior and suggest the kinds of things that would indicate the success of what we were doing in the evaluation process. We saw the difficulties of trying to find out about changes in attitudes, and yet some of the groups who struggled with this developed a pretty clear understanding of the kinds of things that might be involved.

A second achievement was the recognition of need for planning and analysis, for evaluation, and for replanning. This is a continuous process and it never ends. Evaluation, although it sometimes is listed last, ought to get us back around to the beginning again—to replanning. Without evaluation the replanning is a sort of by-guess and by-gosh thing. With evaluation it is also sometimes hit or miss but evaluation gives some leads in the processes of planning.

In addition, we began to recognize that we would have to identify resources and problems of organization. The resources and organization are sometimes much the same sort of thing because the organization has to find ways of capturing the resources but if we did nothing else in many of these groups, however, we found out that there are many resources, not enough perhaps, but many resources upon which we can call.

I was impressed by the appointment of Dr. Hugh Carmichael in the American Psychiatric Association to be responsible within the field of psychiatry for extending understanding of mental health concepts and principles. There is clearly, as some groups recognized, a need for State training officers and possibly for regional ones, meaning sub-State ones.

We made some definitions of resources with the possibility of lifting out of these definitions the ones that are appropriate to particular kinds of activities. Universities, yes. Agencies, yes. Community colleges, yes. Vocational schools, yes. And you could add any number to this: PTA's, libraries,

and on. So that I think if we came here with the feeling that universities were the only place to look for help, we ought to have disabused our minds by now. If we came feeling only the agency could do the job, we ought to have disabused our minds of this also.

In California, several of the mental hospitals have so-called professional buildings. These are buildings for inservice training on the mental hospital campus. You would think that this would mean they were doing all their own training and all their own educational activity. They are not. They are working with the University of California. They are working with community colleges which sometimes are located just across the street from them, as at Napa. They are making a wonderful effort to pull together in that facility the resources that are available to them in that very resourceful State.

It is highly important that we recognize the need to combine resources and I am delighted that we have.

We also became aware that many things were going on in continuing education. There was a good deal of exchange of experiences—in my place we do this and in your place you do that. Many things are going on and many of them can be expanded.

Finally, I think, even in this brief time, language difficulties between groups were being reduced. I did not find people using the same words with misleading differences of meaning. At least we were smart enough to catch these as they happened.

Let me close with some suggestions for the future. I can address two groups only: one is you and one is the National Institute of Mental Health.

Let me start with suggestions to you. The first is based on an old principle of fund raisers. You do not go out and ask for money until you have given some yourself. The more I think about this principle, the more important it seems to be. So I'm going to suggest things that you should do in terms of continuing education for mental health, before you try to get somebody else to do it.

In the first place, find out what is going on within your community or your profession. There will be many things you did not know were going on. The second is the converse of that. Find out what is not going on. I guess you can do that by subtraction. Third, identify the resources available to you. This is partly what we have been doing at this conference. Fourth, propose a program, no matter how small, which you think will succeed. In other words, it is important to do something that you think will have some good chance of success rather than trying to undertake more than that.

Finally, after you have succeeded in your program, let others know what you have done. The clearinghouse function that was suggested for the National Institute of Mental Health is something that has to be done everywhere. It cannot always be done by the National Institute of Mental Health.

Now let me turn to the National Institute of Mental Health.

I have a great admiration for the National Institute of Mental Health, although I objected to the aide training program because it seemed to start at the wrong end. It assumed that the National Institute of Mental Health or the Congress or somebody knew what each State ought to be doing. I do not doubt that the program has done a great deal of good, but I think there were other ways that would have done the job better.

I hope that you, the National Institute of Mental Health, will support leaders in continuing education in mental health in established organizations. To do so may require that you help to establish the leader in State departments of mental health, in the mental health professions, such as Dr. Carmichael, and in extension or continuing education divisions of the universities.

Continue to support mental health programs in regional education agencies such as SREB, WICHE, and NEBHE the regional education agency for the six New England States. Provide funds to universities with adult education programs to establish stipends for mental health continuing educators, for people going into continuing education, or already in continuing education, to study for significant periods of time periodically. Organize an annual conference on continuing education in mental health for perhaps a 5-year period. The value of this kind of interchange is well established.

It is particularly important that you contract with universities to make and publish studies of continuing education in mental health to build a theoretic base for specific activities. Establish experimental programs intended to discover new methods and solutions for persistent problems in the field.

It is my conviction that we must plan carefully, but that we must plan only as prelude to action. It is the fear of inaction, of inappropriate action, that lies behind the phrase "the ivory tower" which has occurred throughout the conference in commenting on universities. It is an appropriate phrase only if you do not get contemptuous of what goes on in the ivory tower.

Let me leave with you one story which has stuck in my mind ever since 1958 when I participated in a conference on graduate education and psychology supported by the National Institute for Mental Health—who else?—in Miami.

A discussion of the curriculum during that meeting was warm and vigorous. Some wanted to adopt a core curriculum. Others feared that such a step would lead to accreditation of graduate programs, which they violently opposed. So the controversy went on and on until even the major protagonists began to tire. They had been supporting and opposing the proposition that some similarity was necessary, that some control was needed, that some teeth should be put into the declaration that graduate education should be of higher quality; otherwise, they maintained, this was just a pious statement. It really had to have teeth. As the argument became acrimonious, Filmon Sanford, then executive director of the American

Psychological Association, asked for the floor to make an observation. He said, "I followed this discussion with interest, Mr. Chairman. I'm not certain what regulation we should recommend, but this much I do know, and I know it with absolute certainty. If we don't put teeth into this regulation we've just been beating our gums." If we can look forward to placing the ideas we have generated here into social action, we can feel pleased with the certainty that we have not just been beating our gums.

Discussion

DR. LUCY ZABARENKO. Hopefully I have not risen to speak about evaluation, but I have been interested in what you were saying about the necessity for relevant theoretical studies based in the university, especially when one thinks of a movement like continuing education for mental health which is action oriented. Would you like to say more about how you could put teeth in that so you can take the bull by the horns and go down the road where you can't see?

MR. MC GLOTHLIN. That's the trouble about saying anything. I suspect what I'm saying is a hope rather than any real suggestion of how it can be done. I know it won't be done unless people who are in the action end of things put a value on it, because the action end of things is so much easier to support. It is so much easier to obtain support for action than for theoretical studies. I have heard, for example, that we have been running, in physics, let's say, for some years on theoretical knowledge we got from Germany and that we have just about run out of this. We shall have to build up our own theoretic base.

If you follow the congressional discussions, the ones we have the worst trouble with are not what are you going to do about cancer in terms of a clinic or in terms of a new surgical procedure, but what are you going to do about physiology or cytology. The interest of the Federal Government up to recent years has been in the categorical. What this means is that you define the disease and then you set up an agency to find the reason for it and to eliminate it, or to try to eliminate it. I once heard Mayhew Derryberry, when he was with the Public Health Service, claim that it was very easy to get Congress to appropriate for disease and very difficult to get it to appropriate for health.

This is the difficulty. I guess what I am saying is that it is going to be possible only as people who are in the front line, the people who are action-oriented, recognize that their action is supported, guided, directed, made possible by the theoretic base on which it rests. It's on some base and the more solid, more sound the theoretic base is, the more likely the action is going to be valid.

DR. FORREST B. TYLER. I've encountered this gentleman by virtue of my being at NIMH and his being on conference programs over a number of years. He made the comment earlier that it seems to him all a conference

does or can do is to define the highest common denominator. I'd like to ask him, as someone who has been at the forefront of innovations in mental health in and around NIMH for a number of years, what he sees as significant changes in the highest common denominator of what we're doing and talking about.

MR. MC GLOTHLIN. One of the things is that nobody is scared of NIMH any more. When the program began people seemed to be fearful that NIMH was going to take everything over, that it was going to run the country. I think this attitude has pretty well disappeared. It seems to me that now we are operating much as if this is another resource—a partner in this operation. I think it is a great tribute to the personnel and policies of NIMH.

The second thing is that I don't get as much feeling of status and role conflict, if I can use those rather difficult terms, as I did. When we first began to see these meetings that would cross discipline lines, people tended to huddle together. You did not see nurses talking with anybody but nurses, psychiatrists talking with anybody but psychiatrists. I get the feeling there is a lot more interchange now than there used to be.

I think that we have moved back some from the categorical into the theoretical. I still think it is easier to organize a conference around what to do about some specific thing than it is to organize one on what is the theoretical knowledge available to a field. How long does it take now to get an article in the *American Psychologist*? The last time I looked it was 2 years, but I don't know what it is now. Maybe four. So that this kind of exchange is pretty important.

We have been able to incorporate in this kind of meeting, sometimes, people who are more community or political figures than professional figures. I get the feeling that professional people are not as fearful of political figures as they were some time back. I think this is to the good. The result is that we are not always just talking to ourselves, and we can possibly suggest to other people that the theoretic base is highly important to any field.

DR. TYLER. I don't know whether it is just a phase in any exchange, but it seems to me that the first time I was at a meeting of this kind there was really a kind of battle about whether there was any point in trying to interact in the community, in the professional agencies and so on. In this meeting, at least, we have gone far beyond that. Nobody has really raised that question. They have accepted the task as a legitimate one to work with, so I guess I would define that as one.

MISS CECILIA CONRATH. I would like to comment on your point about providing support for adult education. If I understood what you were saying, you were encouraging NIMH to explore the provision of support for adult education in mental health, that is, to interest adult educators to work in the field of mental health. Am I hearing you right?

MR. MC GLOTHLIN. Yes. That was the one where, having read it, I began to wonder whether I meant health education or adult education, and I don't really care, you see.

MISS CONRATH. All I wanted to do was to offer the suggestion that this may be one of the aspects the Division of Regional Medical Programs and NIMH may wish to explore together. At the present time we are supporting two rather large divisions through contract mechanisms, training programs, at the postdoctoral level in educational evaluation to work in the medical area. Naturally our interest is heart, cancer, stroke, and we have a categorical emphasis on this. I am only offering this as one of the ways in which these two parts of the Public Health Service may find further exploration mutually helpful.

We recognize the tremendous manpower shortage in the area of training people in evaluation of continuing education efforts, and I think this may be one of the places where we can at least get started together and compare notes on both resources as well as the scope of the program.

MR. MC GLOTHLIN. Wonderful.

SESSION CHAIRMAN MCPHEETERS. From my own point of view I think one of the most significant things I have gotten from this meeting is a little bit more understanding of your program and the tremendous resource I think it offers in tying some of our continuing education efforts together between mental health and regional programs. I think this offers a tremendous resource. We ought to keep in touch.

DR. HERBERT LEIBOWITZ. One of the kinds of things I've picked up during the 3 days we've been here is that with the budget negotiations going on in Washington and all sorts of reorganization, it seems to me that many of the things that we have been talking about, hoping about, for the past 3 days, are kind of threatened by things like Vietnam and domestic budgets, et cetera. And I just wanted to challenge myself and others to look upon this as really a very realistic need for social action.

PART TWO

**Reports
of
Group Meetings**

Introduction

In determining the design of the group sessions, consideration was given to the importance of some structure to maintain focus on the objectives of the conference. Suggested questions (see appendix B) on general topic areas to initiate but not constrain discussion were distributed to the leaders and participants before the first session. They related to specific subjects but allowed for flexibility so that the character and autonomy of each group could flourish. The focus of the initial session was on individual and small group aspects of learning. The suggested sequence of later group discussions focused on school, institution and agency responsibility for continuing education; on community and state involvement in implementing knowledge and skill of mental health personnel at any and all levels; and finally, on the opportunities and problems which must necessarily be considered in organization of mental health continuing education programs at regional and national levels. It was further suggested that special attention be given to organizational aspects of continuing education programs at all levels so that identified program goals could be achieved.

Each of the individuals invited to the conference was an expert in a special area of competence and had a well-known interest in continuing education. The plan was to have nine discussion groups, each made up of at least one representative from each of the identified fields of competence.

Because of travel restrictions, some representatives of Federal agencies were unable to attend the conference as planned. The decreased enrollment necessitated a reassignment of members initially in group E to other groups. This action maintained as nearly as possible a representative and numerical balance of experts in each of the remaining eight groups. Feedback from the small groups to the general sessions was accomplished by the methods described on page 64.

Because of the expertise represented, a specific effort was made by the leaders to encourage all to share their unique contributions for the record. The group discussions varied considerably. The mixture of academicians, practice-oriented executives, and citizen or service group representatives induced interesting and lively discussion. Important questions were posed and ideas rather firmly held by some were often challenged. Members did not always agree or reach conclusions, but when there were points of contrast, expressions were most often identified as those of individuals rather than as of a profession or of practice. One such discussion resulted from a statement questioning the lasting value of 1- or 2-day conferences or work-

shops often referred to as "one shot deals." This type of experience was contrasted with a planned sequence of learning experiences, the value of which it was suggested, could later be judged by trainees' performance. An emphasis noted through most of the discussions was on consumer participation: the involvement of students or target groups in planning for their own continuing education. There seemed to be agreement that learners, whether professionals, paraprofessionals, or indigenous leaders could be recruited and their interest and investment in continuing education sustained only as their participation in planning assured content and methods relevant to job performance and satisfaction.

Group discussions in general began with education and learning associated with individuals. Some groups more than others focused on learning theory, felt needs, motivation, and involvement. Others struggled initially with evaluation but recognized also the importance of preceding such discussion with the delineation of clearly stated objectives for individual or group experiences which were related to program goals. The focus on realistic objectives was stressed by some groups at an early point because of the ultimate need to assess goal achievement.

The importance of methods used in adult education was voiced by many in various groups because of realistic concern about the reasons failures were experienced in some continuing education offerings. The causes of underuse of known viable resources were explored as was the overuse of stereotyped methods such as didactic presentations which often lack a dynamic quality. The value of new methods was thought by many to be underestimated as techniques, and their contributions, therefore, not maximized.

Exploration of the subject of agency-institution relationships remained fairly objective in spite of "vested interests." The discussion which moved to community and State involvement in implementing knowledge and skill in mental health continuing education was particularly stimulating in several groups. While there was consensus that the power structure and the political implications had to be known, the methods of dealing with them or being positively involved remained unresolved. Agreement about the importance of developing more knowledge and skill in these areas was based on the fact that new and effective methods of service delivery must be devised and mounted. These in turn make new demands for manpower.

Organizing for continuing education at State, regional, and national levels was touched on by a majority of the groups. Specific recommendations for action at the national level and particularly for NIMH were also considered and made (see Part Three).

The reports which follow reveal that participants made considerable effort to get at pertinent common factors underlying continuing education in all fields and later to identify specific areas of concern in continuing education in mental health. Group reports varied in style but a minimum amount of

editing has been done in order to maintain, for readers interested in the process, the individuality of each group and the variety and types of contributions made to the concept of continuing education by individual participants.

MARGARET E. HOFFMAN, ACSW

Group A

MILTON GREENBLATT, M.D., *Leader*
C. KNIGHT ALDRICH, M.D.
ARTHUR BRAYFIELD, Ph. D.
DOUGLAS R. BUNKE, Ph. D.
EDWARD J. CARLIN
ROBERT I. DAUGHERTY, M.D.
MARY FLORENCE HILL, Ph. D.

JOHN V. HOTTEL, Ph. D.
HERBERT LEIBOWITZ, Ph. D.
HAROLD L. MCPHEETERS, M.D.
MARK TARAIL, D.S.W.
SISTER JANE CUSHING, *Recorder*
ALLEN J. ENELOW, M.D., *Collator*

SESSION 1

Following self-introductions by the members of the group, several points were discussed and agreement was reached on the following:

- The clarification of role is most significant in the field of continuing education in mental health.
- The constant changing of roles is of key concern in continuing education.
- The nonfeasibility of separating education and training from the needs of patients experienced in day-to-day relationships must be recognized.
- Nonprofessionals have made a tremendous contribution to the overall mental health field. They can be readily utilized as tasks and responsibilities are more clearly identified for this group.
- Lack of knowledge about mental health is a problem for all leaders in a community.
- The potential recipient's lack of awareness of his need for mental health services is a great problem.
- General practitioners want the services of mental health consultants to help them do their job in mental health more efficiently.
- People's real needs frequently differ greatly from what the professionals assume their needs to be.
- The need for continuing education in social and/or mental health fields is best generated among the students or learners themselves.

SESSION 2

Concepts of Continuing Education

Two questions were posed:

What are the key concepts in a philosophy of education? Which are most unique to continuing education?

It was agreed that education is continuous throughout life; that it is experiential, academic, and verbal; and that it relates to the whole man. It was noted that medical education has the strength of being primarily experiential as opposed to being solely academic or verbal. The purpose of

education was seen both as self-development and as a tool to solve problems of everyday living.

In attempting to delineate aspects of continuing education in mental health, that is, what should be learned, by whom, and for what purpose, the following outline was developed through discussion:

Why? (Purpose)

- | | |
|--------------------------------|--------------------------|
| —To treat mental illness | } visible and invisible. |
| —To prevent mental illness | |
| —To promote general well-being | |

Who? (Target groups)

Mental health professionals
Psychiatrists
Psychologists and behavioral
scientists
Social workers
Psychiatric nurses
Mental health workers

Health professionals
General practitioners
Nurses
Technicians
Health workers

Other professionals
Clergy
Legislators
Teachers
Lawyers
Police
Nonhealth workers

*Nonprofessionals and/or
citizen groups*
Community leaders
Service groups

Others
Indigenous leaders
Client or patient groups

What? (Content)

New knowledge: Power, structure, organization, administration, communication, politics, social science.

New roles: Leadership, teaching.

New emphasis: Service through active participation in alternative non-traditional settings.

New skills: Group process.

How? (Achievement of purpose)

Collaboration with experts in own and other disciplines.

Participation and cooperation with consumer or student groups.

Measurement or evaluation of results.

Fund raising.

The problem of planning programs in continuing education for (1) service, (2) teaching, and (3) research, with emphasis on service, was recognized. There was consensus that professionals are by fate cast in roles of generals

but are not always being used by new community leaders who are springing up. There seems to be a move toward more citizen participation but it must be admitted that as yet we don't know whether subprofessionals can do better or as well as professionals in some areas. Many individuals have more potential than has been recognized. Some in the group thought that mental health and health professionals will in the future play a smaller role than is currently taken in contrast to natural leaders who will be emerging in the field.

SESSION 3

Mental Health Professionals as Leaders and Consultants

Some recapitulation of the discussion in session 2 emphasized the group's concern about finding resources for continuing education in mental health. Interest was expressed in knowing more specifics about the program of the Continuing Education Branch of NIMH as well as other resources within the Bureau such as staffing grants. There was discussion of additional topics as follows:

- In the community mental health center, mental health professionals should act as leaders and consultants to the other groups listed in the session 2 section entitled "Who?" (health professionals, other professionals, nonprofessionals, and others).
- New types of functions or roles for psychiatrists, psychologists, nurses, and social workers often result in their becoming professional resource persons.
- The new functions described bring out the fact that mental health professionals are ill prepared to work with the other groups listed under "Who?", i.e., health and allied professions and nonprofessionals. The American Psychological Association is ahead of other professions in relation to expectations of graduates in this regard.
- An action-type solution to fill this gap was suggested through a supervisory approach. Training of psychiatrists, social workers, and some other mental health professionals depends on supervision in the acquisition of certain specific skills but not in the whole range of training.
- Involving mental health professionals, as relevant, in continuing education in the process of *supervision* is action that tends to be fruitful.
- Bringing in pioneers, specialists, and community leaders to perform functions in which they have knowledge and skill can result in mutual learning through interaction.
- Formalizing an informal system can result in some loss of expertise. Professional labels should be forgotten and there should be assessment of where we are and where we want to go. Certain role expectations require expansion of roles, and for this continuing education is necessary. A blending of roles between all those listed under "Who?" can be

upsetting, but the gains are worth it. When this is done, inservice training is needed as is the adoption of new labels to fit those performing new roles.

- Training of key personnel is extremely useful and makes it possible for effective education to be passed down the line eventually to resource people in the community.
- There must be realistic communication between all those listed under "Who?". Seminar-type teaching may not prove as effective as experiential use of psychiatrists as teachers, or training carried out in shop workers' lunchrooms. Education here comes through involvement. But learning by doing can be pushed too far, particularly if personnel are not in reality being trained to perform better the jobs they are actually doing. Continuing education of mental health professionals should progress to a more fluid state in training centers, but it was recognized that the bureaucratic system will take a long time to change.
- Closing the gap between practice agencies and educational institutions is necessary. One way to achieve this is for the universities to have continuing education resources that training centers and agencies can use effectively.

Universities	Professional associations	Agencies
General knowledge.	Roles—attitudes. (Basic professional schools should train for new roles but if new roles develop, agencies should accept the lead in establishing training.)	If new skills needed are very specific, agencies have the job of training and handling these.

- From labor's concept of what is happening, psychiatrists do not resonate to individual worker's problems. Therefore they should get out of their ivory towers and down to the grass roots. If the gap in understanding is too great, mental health professionals will have to go to labor's schools. People in the labor movement want to know about and promote mental health. Labor unions want more wide-range education in the field of mental health for their members. Such knowledge could be specifically helpful in worker's usefulness and as a solution to behavior problems.

SESSION 4

Continuing Education for the Nonpsychiatric Physician

Continuing education is being and becoming interrelated in changing situations. The question was posed: What sort of changes can be built in to affect staff and community in a positive way?

The individual physician has to feel he is giving excellent service. In many

general practitioner programs there is both continuing education and on-the-job training. If continuing education takes place in the field, there must be additional budget considerations as it usually proves more costly.

Oregon General Practitioner Program

In Dr. Daugherty's program in Oregon he talked to many general practitioners initially and asked them what they needed most to be more effective. They replied they needed stimulation and were adversely affected by being bogged down with technicalities. Seminar-type sessions were developed in which experts in mental health were put in contact with groups of general practitioners. Later some of the trainees became teachers of other non-psychiatric physicians. In this planned *learn it, do it, teach it* program, non-psychiatric physicians became clinical instructors and with the aid of a psychiatrist taught two general practitioners at a time. This has become a fundable type of program.

In working with community hospitals—meeting with high status staff people—goals of the general practitioner program were broadly described. This allowed the community hospital staff to particularize their specific goals and plan and mount the courses. Meantime a core curriculum developed—courses were run to meet the physicians' needs and the courses which were built around these needs were planned on certain basic principles. Half of the funding was from NIMH. Hopefully more generic interdisciplinary types of programs will be funded in the future.

Further discussion included the need to involve the target population in planning programs. This is important in terms of making needs more visible.

If continuing education is built into the structure of the program of an organization or institution, better results occur than when it is imposed from without. Agencies have to see results, and obtain rewards concomitant with the training program.

There can be resistance to these programs on the part of the consumer and the administrator. People in power and the consumer must both be involved in developing continuing education programs.

NIMH with emphasis on "continuing education in mental health" has "gone categorical," and this is meaningful in funding. Participants were not generally aware of alternatives to funding continuing education through other than Federal sources.

SESSION 5

A Case Aide Program

The case aide program as used in one State Hospital in Massachusetts makes it possible for one and one-half social workers to run a program for approximately each 200 patients with the help of students and case aides.

The plan under phase I has been in operation since 1953. This involves 10 undergraduates working with a social worker. Each one of the students makes a friendship relationship with one chronic patient. He tries to help in any way he can. If the patient is released, the student continues to maintain contact with him on a followup basis. Thirty percent of the chronic patients have been released since the inception of this program.

In phase II of the program, adult case aides work with the social worker in the same fashion as do the undergraduates. In phase III, the talented undergraduates and the adults working in the case-aide program are selected and trained to take responsibility as leaders.

A Community Mental Health Center Model

New ideas are being implemented in the mental health field. They are now being developed and practiced at the neighborhood level. The example cited was that of the work of Drs. Sheppard Kellam and Sheldon Schiff, psychiatrists who have been successful in working with public assistance clients among others in a Chicago neighborhood. The mental health professionals are not the only ones responsible for reaching the target population. But they help by moving into the community and joining with the community leaders.

Recommendations for Continuing Education in Mental Health

1. Guidelines for the development of a continuing education program need to be implemented.
2. Every major city mental health division offering its own continuing education programs should also be tied into a statewide or/and regional program. Geographic areas such as the northeast, which do not have active regional organizations at the present time, should be encouraged to implement or establish such organizations.
3. A qualified person should be made responsible for coordinating what resources exist—talent, agencies, mental health boards—either regionally or locally to prevent expensive duplication of effort.
4. The group suggested that NIMH take responsibility to provide State staff development offices, or at least consultants in continuing education, to encourage the development of necessary guidelines and to provide expertise for the formulation of successful continuing education programs in mental health fields.
5. The final recommendation was that insofar as feasible the members of this conference on returning to their own regions stimulate the development of regional conferences to be followed with another national conference as soon as the proceedings of this conference become available.

Group B

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SESSION 1

The members of the group introduced themselves and related their individual interests and experiences with continuing education programs for mental health professionals.

Discussion of Plenary Session

The members' reactions to the previous general session were summarized under two headings: (1) commendation of NIMH for its formal involvement in continuing education; and (2) learning—concepts, theory, and practice.

No one questioned the importance of continuing education for mental health professionals; the group was pleased to see the NIMH assume a formal role in continuing education.

Learning Theory

Some of the important concepts in learning theory that were discussed included:

- Involvement of the learner.
- Education as a dynamic process.
- Interests and background experience of the adult learner as important considerations in adult education.
- The desire of adult learners to have education which is relevant to their needs and interests.
- The voluntary nature of adult participation in learning activities.
- Appropriate methodology for adult learning.
- Measurement and evaluation of behavioral change.

The involvement of adult learners in the planning process and the choice of methods for teaching adults were identified as primary issues in continuing education. It was acknowledged that potential learners may not have been asked during the planning process about their interests and needs in subject areas. Dr. Brechler considered involvement as a significant concept in learning and in social change.

The involvement of the learner was also the central issue in the discussion of educational methods. Dr. Levy viewed learning as an active process in which the content of the learning is relevant to the need of the individual as he himself perceives it.

Criticism was voiced against both lecture and small group methods. Dr. Kern felt that adults rebelled against the use of lecture methods when used in continuing education and Mr. Hubbard observed that we usually fall back on the traditional ways of imparting information. It was pointed out that, with a lecture, it is difficult for learners to have a feeling of participation and with a small group, the experience may deal mostly with the process and thus lose the subject matter content.

Mr. Mobley, drawing upon his experience in industry, expressed the view that industry sees the classroom experience as only one area of growth. At first, industrial training was perhaps 85-percent lecture and discussion; now, the inservice education program is approximately 80-percent direct involvement of the learners through simulation and role playing experiences and tutoring the man on the job.

At this point some problems were identified: (1) The failure to pay attention to learning theory; (2) the lack of assessment of the impact of the learning experience; and (3) inadequate understanding of how to apply the results of research. These questions evolved into a discussion of evaluation and measurement of the educational change.

Although one of the group members felt that "analysis kills" and said that he resented an evaluator, Dr. Zabarenko reported a study of general practitioners in which an evaluation was conducted without disrupting medical practice or destroying the people concerned. She pointed out the importance of prior preparation and training of the research team and the value of involving the general practitioner as a member of the research team. It was also pointed out that verbal reports of what a person says he learned should be viewed with skepticism. Often, there are discrepancies between what is verbalized and what a person does in his actual operations.

Some practices considered inconsistent with learning theory were cited:

- Reliance on traditional classroom methods for educating adults.
- Frequent dictation of educational practice by economic considerations rather than by principles of learning.
- Inadequate assessment of the impact of the learning experience.

SESSION 2

Methodology

Motivation and appropriate teaching methods were discussed. It was strongly felt that adults need more involvement in the planning and in the learning experience itself than is usually recognized. It was suggested that the lecture method is overused and often inappropriate. It was felt that adults resent the manipulative efforts of teachers to control much education.

The task of making the learning relevant to the adult's needs and interests is being tried in various ways:

- Simulation experience, such as the Kepner-Tregoe courses which Mr. Mobley reported are used to teach decision making in business organizations.
- Problem-solving experiences using actual problems of the organizations, e.g., budget development.
- Participation labs, which Mr. Rooney described as discussion sessions in which individuals analyze their feelings and personal behavior. Dr. Levy also cited a series of meetings in which Manpower Development and Training Act trainees looked at their own feelings toward their job, and their interpersonal relations.
- Techniques which involve the active participation of the learner, e.g., the in-basket technique.

Locus of Responsibility for Providing Continuing Education

Where should the responsibility reside for providing continuing education activities? The group agreed that mental health professionals should not be restricted to university-provided education. Dr. Levy suggested that the responsibility is actually shared: the individual professional has a major responsibility that can be pursued through reading, consulting, and self-directed study; the employing agency has responsibility for orientation, in-service and supervision programs; the professional associations should provide continuing education activities through conferences, seminars, short courses, graduate study courses, and programs. The university may be in a position to provide needed competencies in specific subject matter areas and in areas of adult education programming and methodology.

The best alternative for mental health professionals would seem to be the formation of partnerships in this effort between operating agencies and universities. Dr. Kraft suggested that a partnership between mental health field agencies and universities would produce better results than separate fundings by NIMH to educational and operating agencies for continuing education programs. Mr. Hubbard saw the agency contribution as essential in any joint effort because the operating agencies really care about the results of continuing education activities.

Measuring Impact of Continuing Education

How do we measure results? Assessment of the impact of any continuing education activity was acknowledged as very complicated. True, the extent of satisfaction with a learning experience and the acquisition of certain kinds of knowledge and skill can be measured. But Dr. Kraft questioned if our criterion should be "Are people enjoying it more?" Dr. Zabarenko pointed out that no definitive research exists as to what the "good" executive, physician, etc., is and does.

The goal definition problem may be equally as difficult. Dr. Zabarenko reported that 8 months were needed to define the goals of one study in operational terms. Mr. Mobley questioned if we even know how to evaluate attitudes and values. It may not be possible to define goals at a very general level in operational terms. But, if we cannot define mental health, or mental illness, or treatment, Dr. Kraft asked the group, do we have to settle for the "traffic" kinds of measures of our work? Dr. Enelow suggested that instructional objectives have to be defined through the interplay of the needs felt by the learner and the conviction of the teaching group about the behaviors which would best meet the needs. If results are to be tested, some indirect measures can effectively be used. For example, inferences can be made about behavior change by determining before and after actions of general practitioners such as numbers of referrals made, the intervening time spent with each patient, and whether or not the whole family is seen.

The group seemed to agree with Dr. Zabarenko's summary that the cosmic questions have not been answered, that general goals are still needed although we should work toward defining goals in unambiguous and concrete terms, and that researchers must observe and evaluate where they can the present methodology. Really meaningful evaluation will involve the commitment of considerable resources.

- Is retention of staff one objective of continuing education?
- How can we deal with the economic factors in continuing education without sacrificing learning theory?

SESSIONS 3 AND 4

Proposed Statewide Plan for Interdisciplinary Training Program

The group explored the question of where and how resources for continuing education could best be invested. Mr. Hubbard discussed a proposed plan for California.

On the assumptions that (1) the department of mental hygiene has responsibility for training a variety of types of people in the mental health field and (2) adequate educational resources exist, the department is proposing to employ staff to bring the educational resources and the personnel together in appropriate continuing education activities. Funds would be used from national, State, and participating agency sources to employ a coordinator in each of the five regional offices in the State under the guidance of a regional advisory committee. The job of the coordinator would include getting and working with an advisory committee, determining training needs of agency personnel, and making arrangements for educational programs to be developed to meet these needs. The sources for providing educational programs could be the universities, colleges, junior colleges, university extension, the two centers for training in community psychiatry, State hospitals, professional organizations, agencies, and public schools.

Whether the coordinator would be hired from the fields of psychology, psychiatry, social work, or adult education is an unresolved problem.

Resources for Continuing Education

The question of the best investment of continuing education resources was raised. The self-supporting characteristic of some university extension services was discussed. Mr. Mobley pointed out that if industry didn't have a 3- to 5-percent increase in staff in a year, inservice training wasn't provided. He thought that inservice education should be recognized as one aspect of a larger manpower system and that training could be an "upsetting" activity to the system. Mr. Mobley also discussed some of the available educational technology that can be used to solve problems of distance and resources. Dr. Kern described the use of a closed circuit, two-way TV at Dartmouth Community Hospital, but also suggested that the group experience would be important for achieving some goals. Dr. Zabarenko stated that the learning climate and the instructor's ease and comfort in the use of a method were probably two important considerations in selecting an educational method to use.

Interdisciplinary Efforts

Problems of coordination and interdisciplinary decision making in organizations with particular reference to providing effective interdisciplinary training programs were discussed. It was felt that the task is difficult, yet relevant if you think of treatment teams. The group felt that interdisciplinary effort probably does not happen spontaneously but develops as a result of common experiences over time as people learn to work with one another. There was speculation that professional schools have either not tried or have failed to help students acquire the values of life-long learning and interdisciplinary problem solving. Tackling a common problem or task would seem to be one way to remove barriers to interdisciplinary effort in continuing education.

Role of NIMH

The future role of NIMH was also of interest to the group. Questions raised were:

- Would NIMH assume a clearinghouse role in disseminating information about continuing education opportunities in the mental health field?
- Would consultant assistance be available from NIMH to assist States and individuals to develop continuing education programs?
- How serious is NIMH about continuing education?
- Can NIMH assist in the coordination of planning of continuing education activities in States and metropolitan areas?

- What is the role of NIMH in developing courses in curriculum or program planning and teaching for those wishing to develop or improve competencies in these areas?

Other considerations:

- What can be done about perceived limitations of resources for continuing education programs such as money, human resources, ideas, sanctions?
- Will continuing programs in the field of mental health be supported for public officials as well as for professionals and allied professionals?
- Will established university departments be in a position to propose innovative projects in continuing education?
- What can be done about the accreditation practices of professional associations that prohibit accreditation for some important forms of continuing education, e.g., consultation?

SESSION 5

Community Role of Mental Health Professionals

Does the professional mental health worker have a community responsibility?

A lively discussion evolved around the role of the mental health worker in community action projects. One argument was presented that once the mental health worker assumes a leadership role in a project such as a rat control project in a slum area he becomes an administrator (manager) and ceases to be a specialist in mental health. A counter opinion was: Why should the mental health professional not get involved in helping a community organization and other professionals control rats or improve schools or improve recreational facilities when a mental health clinic might be 10th on a list of priority needs for that area? Some felt that there are already designated agencies and organizations which have the responsibility to organize the community and mobilize resources for community action. Others were not so sure that this is the case. They were inclined to feel that the mental health worker might be more successful in attaining mental health objectives if he assisted with achieving other goals of the area involved.

The question was not resolved but was left as two questions for mental health personnel: (1) Does the mental health educator get out of his office and into the community? (2) If so, to whom does he talk?

Common Curriculum

The question of a common curriculum for all mental health professionals was alluded to. Even if it were possible, it probably would not be desirable to have one curriculum of inservice or continuing education. Some universities will respond to the continuing education needs of mental health per-

sonnel, other will not. The philosophy, tradition, and reward system of the institution, the sources of its support, and the special interests of its professors will all play a part in the kinds of continuing education programs that emerge.

Evaluation

The session ended with a brief discussion of the evaluation of continuing education activities. It was pointed out, in the absence of valid data, that programs will survive if they are seen to be "useful." It was felt that continuing education programs should be challenged by new research findings and new theories, otherwise much "useful" inservice training would be provided merely to perpetuate an institution.

Group C

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SESSIONS 1 AND 2

Continuing education in mental health and the mental health function are intertwined. One defines each in terms of the other. In defining both of these concepts, one starts with a general response, a general idea of mental health, which then becomes more circumscribed. This movement from general to specific is a dynamic, a process which feeds from one to the other.

Programing Continuing Education

The discussion was started by Dr. Hargrove who outlined the program in postprofessional continuing education for psychiatrists in North Carolina. The question he placed before the group was: What approach should be used to improve the competency of mental health personnel: should the approach be formalized education within professional groups or a reality experience approach such as Kellam's group is attempting? Dr. Carmichael pointed out that there is very little continuing education in the mental health field for professionals with the possible exception of nursing and social work. He felt it would be good to have a change from the present way of operation but thought the problem for psychiatrists was motivating them to be involved in postprofessional training.

Dr. Kellam stated that mental health functions are evolving so fast that it is hard to tie the function down, and that the program gets changed in the political arena so that nonprofessional and political agencies are involved as well. Dr. Wittman asked if equal priorities should not be assigned to postprofessional continuing education as well as to systematic efforts to change education in basic programs.

Dr. Blau, who has been working extensively in the field of programed instruction, called for the consideration of terminal goals. He felt that in order to build a sound educational program, a good design is needed. He warned that one should not ask experts for the design as they could not supply a simple enough framework. It is his opinion that generalists should

design a program with terminal goals and experts could then put the "meat on the framework."

Following much discussion of what terminal goals were desirable in the continuing education of mental health personnel, two ways of defining mental health programs and continuing education in mental health evolved.

Dr. Kellam said that goals should be specific. One defined a target audience, such as a population of 16 year olds, and then decided on how one could operate to effect good mental health in that population. Mr. Held introduced the Brookings' plan for defining target areas in public policy fields. Broad educational goals are obtained by examining three areas: knowledge, attitudinal reflections, and tools of performance to deal with these problems. The institution then specializes its programs for specific groups. He emphasized that they take the position that nothing is hallowed and that they are prepared to use any methods or program to obtain their objectives. When questioned as to how the Brookings Institution judged the effectiveness of its programs, Mr. Held acknowledged that they are only able to do this successfully in the knowledge area.

The viewpoint of the economist as espoused by Mr. Held was supported by Dr. Kellam. He felt that we have not been economical in our efforts, and that there must be more awareness of the economic aspects of problem reduction. He emphasized that this could be done more easily if the target audience is the community. One could then measure problem reduction by two types of behavior: socially adaptive and symptomatic.

Dr. Enelow challenged the assumption that the community approach was that easily evaluated, as one had no way of measuring intervening variables. He felt that one can measure cognitive and attitudinal change but that one cannot positively link it up with behavioral change.

Mr. Littlestone agreed with Dr. Kellam that educational and functional goals have to be separated. He argued, along with Dr. Kellam, that the place to start was to define the population and the strategic points where intervention would result in goal accomplishment. He felt that one should not only look at the high risk populations but also look at other populations such as the school-age child. He criteria as to its success in working with population groups such as these, would then revolve around two questions:

1. Am I helping to keep this child in a regular classroom?
2. What success am I having in keeping the adult at home with the family and on the job?

Without criteria such as these, he felt that the profession faces sophistry and mismanagement of economics.

The discussion then moved back and forth regarding how one would determine goals. Dr. Blau argued for specific terminal objectives. Dr. Wittman questioned whether research objectives could be realized in action programs without contaminating their efficiency. Mr. Littlestone and Dr. Kellam argued that the only way to isolate and deal effectively with goals

was in the field. Mr. Kinney warned that goals had to be specific; if your objectives were not well defined, you were in danger of overselling yourself.

At this point Dr. Hargrove redirected the discussion to Dr. Kellam's description of the Woodlawn project where seven out of 10 first graders were found to need help from the mental health center.

Dr. Kellam described the method used in Woodlawn to respond to mental health needs. Criteria were set up to help teachers recognize whether adaptation to the first grade was adequate.

All children not considered "making it" were referred to a community representative who had been trained to visit in the home and converse with the family. The agencies would then collaborate around this person to play their roles in assisting the child. He described this as the "door-to-door" model. He also described the "store front" and "travelway" models. Dr. Kellam pointed out that regardless of social class, 10 percent of the children in school are not "making it." He thinks that social adaptive criteria might be the answer to predicting social maladaptivity.

There was some discussion as to whether too much pressure was being put on the school when Dr. Wittman raised a question about family responsibility. It was generally felt that criteria would depend on whether the individual was adapting in the dominant arena. It seems important not to define populations in terms of any one social class. It was suggested that an input-output model should be devised where mental health for the whole community could be defined in positive rather than in negative terms.

Dr. Hargrove then summarized the discussion: "The theme I've picked up is that we start with a general response—with a general idea of mental health—which then becomes more circumscribed." There was general consensus that there is a process going on between a general and specific response in the mental health function which is dynamic, each feeding the other.

SESSIONS 3 AND 4

Goals of Continuing Education

A definition of the goals of continuing education was agreed upon and case studies were then discussed to illustrate how continuing education based on this definition could be brought about.

Definition

The terminal goal of continuing education in mental health is the training of responsible mental health workers in the diagnosing and treating of the mental health needs in a community. (The mental health function is defined in the political arena.)

Case Studies

Two geographical communities, Woodlawn and the State of California, were discussed as case studies showing methods of analyzing community mental health needs. One occupational community, the profession of psychiatry, was considered in a similar manner.

The Woodlawn Model

Models were discussed illustrating ways of approaching a community such as Woodlawn (or any community unit of 100,000 persons). Dr. Kellam identified the following models:

1. *Door to door*—moving into a community by identifying the power structure, negotiating with them on the problems of mental health, identifying target areas, and implementing program through a grass roots agency.

2. *Company store*—agencies and professionals analyze the needs of a community, plan the services, and bring solutions to the community.

3. *Travelway*—find the systems of travel around a community and locate services which intercept the community as it moves about.

4. *Community model*—a community representative is employed by the political organization within a community with each block having its representative. The community organizing is done through this person as well as agency personnel using this person collaboratively in identifying needs within that person's jurisdiction.

The door-to-door model was used in Woodlawn. The community model was suggested by the community itself following the actual program implementation.

It was generally felt that the community must be involved in identifying mental health needs and that agency personnel must be there to provide theoretical concepts and technical know-how. The plan of action would then be arrived at through mediation and bargaining.

Dr. Kellam's description of the Woodlawn Center emphasized that the community is responsible for identifying health needs. He pointed out that a \$4 million project was turned down because the community wasn't taken in on it. He suggested that continuing education in mental health must be defined in the context of the community mental health strategy.

There then developed a conversation around how continuing education in mental health should be conducted in such a setting. Dr. Wittman suggested that part of the job of continuing education is the professions' and part is the responsibility of the educator. Dr. McKeachie pointed out that the mental health professional is the target if one is to consider the use of this community model in continuing education. He also suggested that part of the program of continuing education should be how to tie into the political structure. Should mental health personnel, for example, be organizers? Discussion then centered on how to identify the power struc-

ture, how to develop a consensus and how to train people in community diagnosis. Dr. Bateman offered examples from VISTA which showed how important it is to involve all groups.

Mr. Littlestone then outlined how he had seen the community approach used in California. Here the "people" were probation officers, public health nurses, welfare workers, teachers, ministers, police, State hospital personnel, detached workers involved with gangs. Prestige interest groups were VISTA, OEO, Headstart, community mental health centers and comprehensive health planning.

He pictured a community of 100,000 as a series of boxes with the organized older services as one box and the newer function as another smaller box. The doorway into the community was social pathology, (1) the welfare line, and (2) the mental illness line.

He saw professional schools and professionals as two overlapping boxes which by accident of location might be in the 100,000 population group designated as a community.

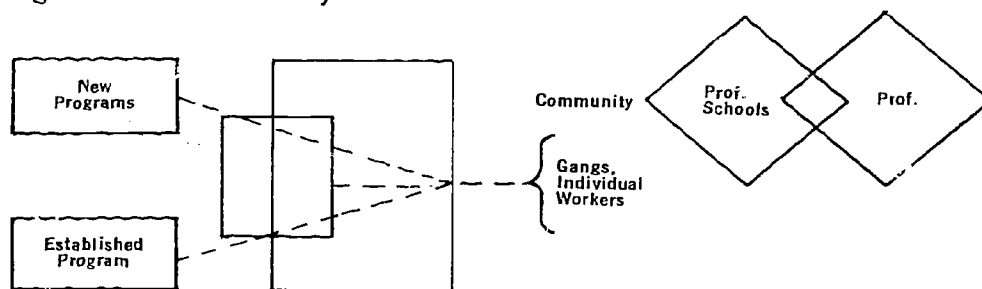


Figure 1.

There then evolved a discussion of how to determine focal points in such a community for educators and how one brought together the professional and the nonprofessional all needing new knowledge and skills in such a setting.

Dr. Littlestone went on to say that in the Los Angeles area there are 160 services but only three of these are in the area where Watts and Mexican-American groups are located. He also pointed out that there are 400 psychiatrists in nearby Beverly Hills. In this situation the universities (USC and UCLA) talk as if they are interested, but there is actually little if any action.

Dr. Kellam felt that in this situation, the boxing off of a 100,000 population unit made "community concept" too amorphous. The community must be able to force the medical schools to address these unmet needs, unless the company store model seems to be the answer. The local structure, all agreed, would have to become discrete and visible. Chicago with its 76 discrete communities presents a different picture than Los Angeles.

In considering the State of California as a community it was felt that many of the same problems as have been discussed exist but on a different scale. Problems seen in determining the mental health needs in this situation were as follows:

1. The lower power structure must become discrete and visible or communities will reject even the best of ideas (i.e., Public School 201 in New York). So identification of community needs and resources is basic.

2. There must be an understanding of the political structure, and alliances must be effected to break down isolationism of the professionals, to get action as well as interest.

3. There was discussion, but no agreement, as to how best to cooperate with social service personnel operating in the community. Some felt they definitely should be involved, others felt that they were too "tied down with the bureaucracy."

Two models relating to the importance of community involvement were introduced by Mr. Held: (1) A political setting for decision making; and (2) a plan for diagnosing and treating mental health needs in a community as a definition of continuing education in mental health. Figure 2 below relates to a way of achieving the basic goal: the improvement of mental health.

Many in the group questioned the model as being "nonrational" and "very conservative." Some felt it would be hard to move the status quo. Some questioned where the public interest would be. Mr. Held maintained the

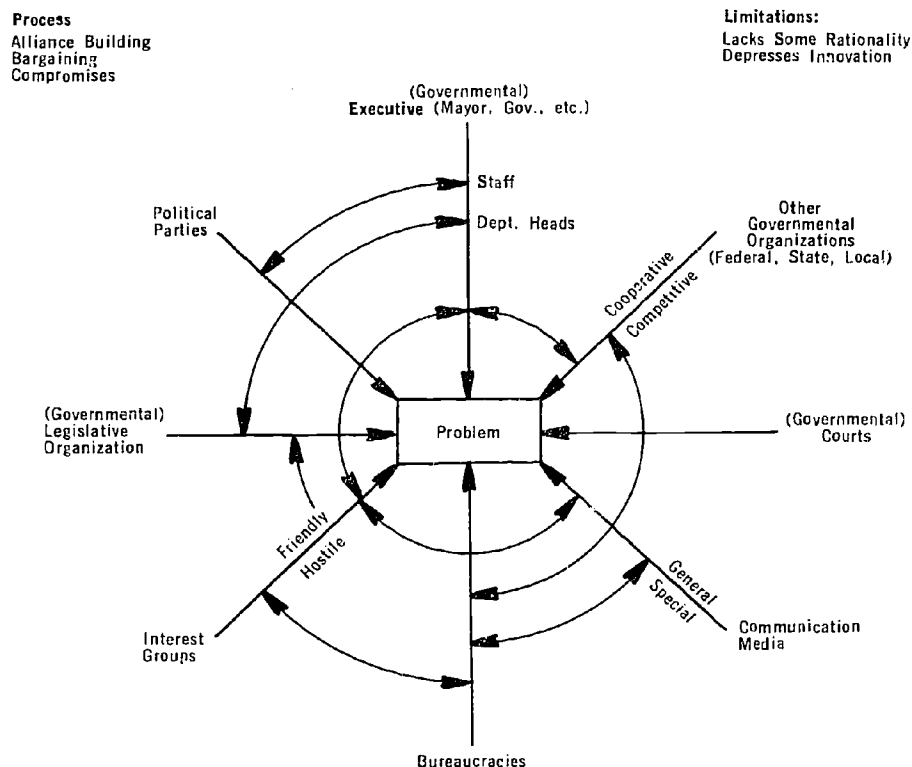


Figure 2.—A POLITICAL SETTING FOR DECISION-MAKING

public interest created and saw this model as a "situational approach." Dr. Kellam noted that in the inner city poor people are powerless and would not be represented.

Mr. Held then proposed another structure for continuing education in his second model (figure 3 below).

Plans Organization Methods Procedures Techniques	Educational goals Target groups	Knowledge	Attitude	Behavior	Tools for reference
	1. Family				
	2. Teacher				
	3. Individual				
	4.				
	5.				
	6.				

Figure 3.—A PLAN FOR DIAGNOSING AND TREATING MENTAL HEALTH NEEDS IN COMMUNITY

Problems and Other Issues

It was felt that the basic problem faced in any of these models was one of "engagement." The professional gets "hung up" on his own identity and has the problem of engagement with his community.

It was suggested that community diagnosis may be harder to teach than medical diagnosis.

It was thought that dealing with bureaucratic structures is extremely difficult.

To enlarge on the last point, Dr. Wittman reported that in New York City there are 6,000 personnel in the welfare department with a one-third loss per year and an average caseload of 60. He pointed out that welfare administrators are caught in a trap and mental health people must comprehend this. There was discussion on how to provide continuing education to social workers. No conclusions were reached after the magnitude of the problem had been discussed.

At this point the discussion shifted with Dr. Carmichael's statement that he felt one problem in the American Psychiatric Association's continuing education program was that they have been educating nonpsychiatric physicians rather than psychiatric personnel. In considering methods to motivate psychiatrists in continuing education, Dr. Hargrove suggested that the psychiatrists be seen as a "community." Dr. Kellam resisted this idea, and suggested that since there are now 300 mental health centers, this was the place to train them. The group voiced strong dissent to this idea.

Dr. Carmichael stated that psychiatrists do not want to be reeducated. He felt it would have to be done by legislation or in some way legitimatizing his becoming a student as illustrated in the Brookings concept. Mr. Little-

stone pointed out that community mental health centers will not accept the responsibility to provide mental health to the population and keep psychiatrists in one area. He felt the APA has to recognize its responsibility in the public sector and to accept the responsibility for the caseloads of various areas. Dr. Carmichael thinks his work must start with chairmen of departments in colleges and universities and with State commissioners. Dr. Kellam pointed out that many of Chicago's psychology departments are moving into the community and that he felt this was a political process based on mutual self-interest. The remainder of the time was spent in discussing how one might educate psychiatrists in the same way that Brookings educated high-powered executives. Mr. Held was optimistic about the possibility. Dr. Kellam questioned how vigorously these powerful people were engaged. To him, engagement is crucial.

SESSION 5

Recommendations to NIMH

Discussion centered around three recommendations to the NIMH from the group: (1) Emphasis should be placed on planning development grants; (2) NIMH should act as a clearinghouse for disseminating ideas about unusual continuing education programs; and (3) professional educators should be an integral part in the planning and development of continuing education programs in mental health.

Planning and Development Grants

The group concurred that there was a need for funding which specifically allowed for planning and development of programs in continuing education in mental health. It was felt that this would make the need for continuing education programs more visible and that it would foster action programs.

NIMH as a Clearinghouse

A need for a clearinghouse for ideas on continuing education programs was felt by the group. Discussion centered on ways of communicating and making the best use of regional and individual work being done in the field. The recommendation from the group was that the NIMH was in the best position to provide feedback.

Role of Professional Educators

In discussing the role of professional educators in the development of continuing education programs, it was the consensus of the group that these educators should be permanent members of the team rather than advisers. It was also felt that professional educators should play an integral part in those programs of continuing education funded by the NIMH.

Group D

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VICTOR I. HOWERY, Ph. D., *Collator*

SESSION 1

Dr. Griffith opened the session by introducing himself and then asked each of the participants to spend 10 minutes speaking to the person on his right so that each person in the group would briefly introduce someone other than himself. The group then briefly discussed how the group sessions would operate and some alternative plans for attack were discussed.

SESSION 2

Dr. Griffith opened the session suggesting as a plan of attack: (1) consideration of questions 4 and 8,* (2) critique of the speeches presented at the plenary sessions, (3) discussion of participants' personal objectives in coming to the conference. He then asked for other suggestions from the group.

Target Audiences

There was a brief discussion about the audiences who are to be the targets for the continuing education being discussed at this conference. The main concern seemed to be that the prospective program should be extensive because community mental health centers and other mental health agencies demand the cooperative efforts of the four core mental health professional groups as well as the nonprofessional groups who work in mental health occupations. Dr. Griffith suggested, however, that it would be more efficient to identify and deal with one target audience at a time.

Identifying Needs

In the discussion on means of gathering information on the needs of various target groups, Dr. Kemble pointed out that programs must involve

*The questions:

4. How can the unique contributions of participants, teachers, and/or leaders be identified and utilized most positively in an adult learning situation?
8. What are the motivational factors involved in an individual's participation in continuing education programs?

the participants in the planning process so it is appropriate to their needs. She also suggested that the teachers should take into account prior knowledge of the participants in order to further involve them.

Dr. Ossario said that in getting a mental health inservice training or continuing education program underway, the person responsible has two choices regarding sequence:

- He can put the staff through a training program before it begins its work, or
- He can put the staff to work immediately and later introduce the continuing education program when the staff realizes that it needs such a program.

The first choice involves dealing with needs the staff does not yet realize it has; and the second choice seems to waste valuable time. Dr. Ossario commented that educational opportunities are liable to be ineffective unless the group recognizes the need for education.

It was suggested that it might be effective to identify the natural leader of the student group and convince him of the need for continuing education. He could then convince the others.

Dr. Griffith noted that there seem to be two dimensions to the problem of needs: (1) People must recognize their problems, and (2) decide who should have responsibility in their solution.

Dr. Chope reemphasized the importance of basing training on the felt needs of the participants. If such need is not felt, it should be developed in the participants. Dr. Griffith concurred, saying that it is not enough for the leaders to be aware of the needs; such awareness must be developed in the participants.

Objectives and Priorities of Continuing Education in Mental Health

The group was asked to identify its most pressing problems and then to focus on these one at a time.

Dr. Ossario said that the problem in Illinois is to reeducate professionals to take advantage of the potential usefulness of nonprofessionals; to maximize professional potential through effective use of a complementary staff.

Dr. Perkins pointed out that the mission or goal of the continuing education program should be identified before talking about appropriate training. The participants must agree on the aims of training if it is to be effective. Dr. Chope suggested that it would be helpful to make a list of objectives and then assign priorities to them.

Dr. Kemble noted that, as Dr. Paolitto had implied, we must sometimes bring the training to the group rather than the other way around; we must bring the training to the job situation. Dr. Perkins added that few professionals are trained in community work in professional schools as he thinks they should be. How else do we help them to move from clinical to the

community situation? Dr. Long suggested that perhaps this should be the top priority item.

Dr. Paolitto went somewhat further however. He said that it is not just a question of how to move clinicians into the community situation but how to train them to work with nonprofessional staff members. Dr. Long commented that it is more important to talk about the community as a whole rather than a community as circumscribed by the walls of a hospital.

Elements in Effective Continuing Education Programs

Mr. Lamson said that the most effective teachers of adults are those who know their subject matter from both training and experience. He suggested that teachers should not be too far removed from what they are teaching; and that the participants and people working in the content area in which the participants will be trained should be involved in the planning of the training.

Dr. Perkins added that teachers of continuing education programs must not be too biased by their own specialties. He stressed the need for an advisory committee for planning, using people and teachers from outside the mental health field in order to bring in new ideas and avoid professional bias. It was recognized that both attitudes and skills should have consideration.

Dr. Kemble said that we need experts *and* good teachers. One will not be effective without the other. Dr. Ossario agreed but added that the teacher should also be a model for his students.

Dr. Holden introduced another element: the climate of the institution. He asked: "Will it support learning and continuing education? Will it be problem or task oriented rather than specialty orientated?" He pointed out that staff members should be generalists as well as specialists. Dr. Ossario suggested that the education of groups or teams is also important. Individuals may function well independently yet fall apart in a group situation. The issue is what factors are important to teamwork and how we can educate for these factors. Dr. Perkins asked whether he was discussing teams who ordinarily work in the same location or teams where the individual members are geographically separated in the course of their work? Dr. Ossario answered that he was discussing both. The first kind might be a ward team and the second a communitywide group. He suggested that it is important to know how individuals within the group can be trained to play multiple roles.

Dr. Perkins then noted that the discussion seemed to have changed directions since Mr. Lamson's point was made. And he suggested putting the two points together, talking about participants and teachers at the same time. Mr. Lamson added that goals must also be a part of the discussion.

Dr. Perkins summarized the discussion:

—There must be a well-defined felt need on the part of trainees.

- There must be a purpose, goal, or training task upon which to focus.
- Instructors should be able to contribute from personal experience.

Dr. Long added that it is also important that the potential teacher or leader be familiar with the problem toward which training is to be directed. Mr. Herman suggested that the participants also need to have a favorable attitude toward continuing education. Dr. Ossairo commented that motivation, effectiveness of learning, and acceptance of learning depend on (1) social motivation toward learning, (2) the work situation, (3) the aims of the group and the role of the leader in defining them, and (4) the nature of the learning situation, especially the composition of the group—administrators, students, and teachers, etc. He added that in such a context there comes about a blurring of student and teacher roles in the total learning situation.

SESSION 3

Available Resources for Continuing Education in Mental Health

Dr. Griffith opened the session by describing certain of the resources which are generally available in the field of education. He noted that adult education since 1935 has been a field of graduate study leading to Ed. D. and Ph. D. degrees. At present graduate programs now exist in 19 institutions. Some 40 professors of adult education have done research and written in this field. A rich literature in continuing education is developing, including

- Harry Miller, *Teaching and Learning in Adult Education* (Macmillan, 1964).
- J. Roby Kidd, *How Adults Learn* (Association Press, 1959).
- Gale Jensen, Wilbur Hallenbeck, and A. A. Liveright, (eds.) *Adult Education: Outlines of an Emerging Field of University Study* (Adult Education Association of the U.S.A., 1964).

Dr. Griffith pointed out that if the continuing education problems could be clearly identified these and other resources could be used advantageously.

Educational Institutions and Agency Relationships

The group then briefly discussed the problems faced by an agency which tries to collaborate with a university. There was complaint that universities tend to be rigid and that programs developed along the lines of disciplines within a university are not always effective. It was suggested that the term university was being used in too general a way. One deals with individual universities, individual departments, and individuals within departments. It was suggested however that university extension divisions and adult education personnel are often better attuned to the needs of leaders of continuing education than are subject matter specialists. Also they can direct continuing education leaders to those university people who want and are able to help.

Dr. Ossario noted that there is often a problem of timing. Mental health people cannot wait for a university to develop a program for them. As a result mental health continuing education programs are often created hastily, hopefully to be revised as necessary. Dr. Griffith supporting this view added that historically and currently universities have been unable to operate on a crash basis. Dr. Kemble said that unfortunately we seem to keep on having to "start from scratch." Ordinarily neither the universities nor any other available resources are well used when programs are planned.

Dr. Ossario reemphasized the immediacy of the needs of the leaders of mental health continuing education. He pointed to additional problems of finance which are involved in collaboration between mental health agencies and universities. He suggested that public agencies and educational institutions should also collaborate on fund raising. He also proposed the general principle that whatever can be done by educational institutions in the area of continuing education should be done by them, since mental health personnel are not educators.

Dr. Kemble deplored the fact that mental health personnel are too oriented toward their own disciplines and that this tends to disrupt communication with others. She suggested that we must become generalists, in the sense that Dr. Holden described earlier: that we should determine our problems and, then, get on with the task. She added that we pretend that everyone is an adult educator but this is not so. Those who are adult educators should be allowed to do their job and others should not attempt to do it for them.

Dr. Griffith pointed out again that the first task is to identify problems and list their priorities. It is important that the participants be able to see beyond their own disciplines and develop strategies to action. Hopefully that could start at this conference.

Dr. Kemble summarized this session:

- We were made aware of the fact that much thought has already gone into the area of continuing education; and that those involved should become familiar with the basic literature in the field.
- We must learn to use the resources in the educational community and seek out whatever other resources are appropriate.
- We must go beyond the boundaries of our several disciplines in order to look at the broader task of continuing education; we must become generalists.

SESSION 4

Problems Involved in Establishing Mental Health Programs

Dr. Perkins led off the discussion by asking how the others in the group would approach the problem of setting up a community mental health plan—a regional system for the delivery of mental health services. Different communities need different services. There is no group to plan this develop-

ment so clinical personnel are having to do a job for which they are not prepared. The basic question is how to use continuing education to help mental health professionals develop programs tailored to specific communities.

Dr. Kemble added the further question of how to insure the necessary coordination with regional mental health services. She recommended the establishment of an overall planning group. Dr. Ossario commented that the demand for coordination of all health services will increase. Dr. Perkins pointed out that the model cities program, community health centers, the OEO, etc., have to be taken into account. The mental health center is not there alone.

Dr. Griffith made the observation that when any professional group recognizes a problem the tendency is to make uncoordinated individual efforts to solve it rather than plan for its solution. Once again he encouraged the group to discuss problems and priorities.

Dr. Perkins suggested a survey of the community to determine problems and resources. Dr. Chope gave an example of involving citizens and thus gaining both information and the citizens' support. Dr. Griffith asked who should get involved and what do they need to learn to get involved effectively? Dr. Ossario answered that there are individuals with special training—usually with a social work background—who are supposed to know the community. They should be involved. Also use could be made of census data and public health surveys, etc.

A Model of the Development of a Continuing Mental Health Educational Program

To help clarify what groups are involved in a State plan for community mental health centers, Dr. Ossario presented a diagram of an actual situation (see figure 1).

The director and the community organization man begin to talk to the target community to get support for the plan. Other staff members also talk

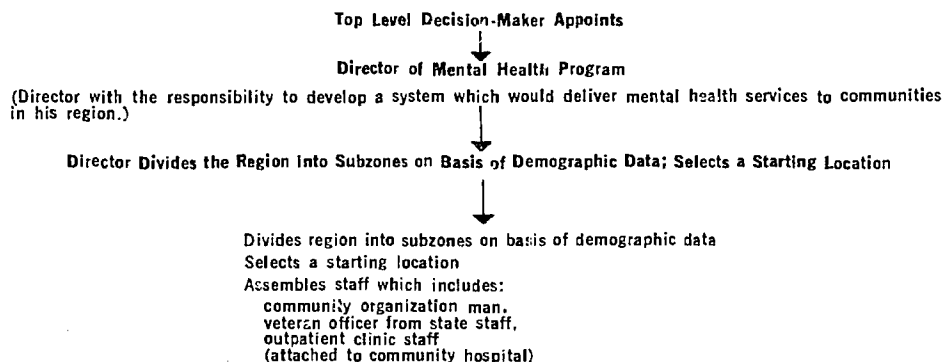


Figure 1.—GROUPS INVOLVED IN STATE PLAN FOR COMMUNITY MENTAL HEALTH CENTERS

to groups in the community. People at all levels will have to begin to do things that they have never done before; to give service in areas in which the outpatient clinic staff considers itself to be and is expert.

Three major audiences needing continuing education were identified: (1) The regional director and his staff, (2) the citizens advisory committee, and (3) the mental health center's professional personnel.

Dr. Griffith asked which group had priority? Dr. Perkins suggested that we must work with all of them at once. Dr. Ossario replied that they were already working with all three but they really did not know how to do it most effectively.

The group agreed with Dr. Griffith that a three-pronged approach was needed. He then suggested that one prong at a time be examined. The substance of the ensuing discussion is presented in table 1.

TABLE 1.—*Tasks involved in setting up a continuing mental health education program.*

Tasks	Group 1 State and community Professional personnel	Group 2 Advisory or citizens committee	Group 3 Center staff
1. Decide on functions of advisory committee.	X	X	X
2. Learn how to get funding.....	N.A.	X	N.A.
3. Learn how to form an advisory or citizens committees.....	X	N.A.	X
4. Learn how to measure dimensions of the mental health task and how to tailor pro- grams to these dimensions.....	X	X	X
5. Learn to develop managerial skills.....	X	X	X
6. Learn to develop program of specific train- ing for component services of the mental health center.....	X	X	X
7. Restructure professional curricula to in- clude training relevant to community mental health centers.....	X	X	X
8. Evaluate program.....	X	X	X
9. Liaison with other urban agencies.....	X	X	X
10. Education and reeducation of the commu- nity in preventive measures.....	X	X	X

The chairman then asked which of the tasks should first be dealt with. After some discussion Dr. Ossario suggested that the group might well concentrate on learning how to measure the dimensions of the mental health task and how to tailor programs to these dimensions. It was also suggested that a number of the other topics could well be included in the discussion of task 4. Some of those topics are:

—Training in communication skills, including interviewing skills and

skills translating statistics into information bearing on the mental health program.

- Group participation in the process of identifying needs.
- Developing familiarity with existing data and their shortcomings.
- Forecasting future needs.

In general, the group emphasized factual approaches rather than intuitive inquiry and long-range planning rather than ad hoc crisis-generated programs.

SESSION 5

Dr. Ossario noted that at the previous session the mental health people had brought out their problems and suggested that the education people might like to react to them.

Dr. Holden referred to a book about the retraining of a small town elementary schoolteacher to teach her how to release her own creativity. Her new learning was successful and she was thus able to help her students release their own creativity. Dr. Holden went on to say that there still seems to be a great deal of rigidity in all of us and we are less effective because of it. We need to create a climate in which people can change easily without losing face. He noted that psychiatrists have difficulty relating to psychologists, psychologists have similar difficulties with social workers and with nurses. All four disciplines in the mental health field need to work to develop a climate that will create a coordinated approach to the problems.

Dr. Holden, noting the problems of communication within mental health teams, suggested developing a system of communication or ingroup coding that would help the staff talk more easily to each other. He also added that the group leader should not be overlooked in the process of continuing education.

Dr. Ossario stressed the importance of the concept of unit training as opposed to individual training. He felt that the mental health field accepts the notion of unit or group training more readily than other groups because of its professional training which stresses close relationships with patients. He suggested, however, that some sort of sensitivity training is needed to solve some of the problems faced in mental health continuing education. However, sensitivity training and similar kinds of human relations training have remained largely outside the purview of the universities. He suggested that some way be sought to bring sensitivity training and university training together. Dr. Ossario pinpointed at least two barriers in the way of coordinating resources and especially human relations training resources: (1) It is impractical to send individuals, let alone teams, to Bethel or elsewhere; and (2) consultants cannot reach enough people. It would be helpful, if it were possible, for such institutions to form regional centers. Dr. Holden noted that the University of California School of Nursing is developing its own training program. Dr. Long agreed on the potential usefulness of sensi-

tivity training; however, he also noted that this group did not seem to be involved in the discussion.

The group urged Dr. Griffith to comment on the problem as an adult educator. Dr. Griffith replied that he would talk about two different levels. First, on the theoretical level, he noted the literature differentiates between cognitive and affective learning and suggests that there are different objectives related to each level. He recommended two books by D. A. Krathwohl as resource material, *Taxonomy of Educational Objectives: The Cognitive Domain*, McKay, 1956. This would be a valuable resource in the development and evaluation of cognitive programs; and *Taxonomy of Educational Objectives: The Affective Domain*, McKay, 1964. This would be a valuable resource in programs dealing with attitude or other affective changes.

On the operational level, there are programs like the current work with the Office of Civil Defense at Staff College. They asked for help from the department of education of the University of Chicago. At the first meeting the instructors and the director were present. The director had been alerted, however, not to say anything since the point of the meeting was to find out from the instructors the problems they believed were hindering their effectiveness. The procedure went as follows:

1. The problems were prepared of the problems as suggested by the instructors.
2. The problems were reorganized according to priorities as set by the instructors.
3. The instructors were asked to commit themselves to work on a committee dealing with one of the problems. If no one volunteered the problem was dropped from the list.

Ten committees were formed and the director agreed to allow the staff time to work on the problems. The first problem attacked was the alleged lack of communication between Staff College and the OCD staff at the Pentagon. It was decided that a residential conference might be the most appropriate educational format in which to tackle this problem. Such a program was planned and selected readings were made available to the participants. The readings were coordinated with the felt needs of the instructors; a library was also provided. Later workshops were held on evaluation and communication skills.

In general, the starting point is with the group's felt needs and then to move toward the other needs that were recognized by the director and the consultant-instructors felt needs. Dr. Griffith in response to Dr. Long's question stated that the readings selected were based on the instructors' needs as expressed at the initial meeting.

Dr. Long noted that Dr. Griffith's program appeared to focus on cognitive areas rather than a variation of sensitivity training.

Dr. Ossario asked about followup procedures. Dr. Griffith replied that they are still working with the group which has the problem of continuing a regular work schedule while engaging in this training.

To an inquiry about turnover Dr. Griffith replied that seven new staff members had joined the project since its beginning.

Dr. Long asked about methods of instruction. Dr. Griffith replied that they try to use whatever format seemed appropriate: residential conferences, group work, classroom work, etc. He stressed the importance of dealing with the individual "burning problems" as they arise. Otherwise, there is the risk of losing the cooperation and support of some of the participants.

Dr. Long reported that one of the problems is that most psychiatrists and other mental health professionals do not have teaching skills, let alone a whole range of teaching skills, and therefore they do not often ask what the group's needs are. Dr. Griffith remarked that his group does not pretend to have all the necessary teaching skills or content information; it feels free to bring in specialists to contribute and evaluate what has been done.

Dr. Perkins recalled table 1, which had been presented earlier, and asked how it could be used. Dr. Griffith replied that the next step was to list priorities and then define specific tasks that will accomplish the objectives. These objectives should be defined in terms of the desired behavior. He suggested that the audience be sounded out to determine whether or not they feel the same needs. If they do then relevant programs can be developed.

Dr. Ossario noted that the problem is that before one can request funds or make expenditures, one has to have a plan. Yet all too often a consultant is needed to help make the plan and the agency cannot make the expenditure to hire him. Dr. Perkins agreed and then remarked that what we need is someone to help us translate our gut reactions into educational terms.

Dr. Griffith noted that a private university usually cannot provide initial consultation gratis. A good example, however, of what can be done is the type of contract the department of adult education has with the Office of Civil Defense. This contract is very flexible; it does not specify exactly what will be done. Thus a certain amount of trust between the contracting agency and the educator exists. It is important not to tie the hands of the educator before he starts working; he must have the flexibility to change his approach as the needs of the trainees develop. You should find someone you can trust and then agree to work with him.

Dr. Howery commented from the public university's point of view. At the land-grant universities a professor could be assigned without cost through the initial stages of planning in order to determine whether or not the university could help in the particular case. After the decision has been made to commit the university to the project, the contract is written.

Dr. Ossario stressed that the point is that someone must put up the risk capital to explore a problem. Dr. Kemble said that it was good to hear that university people could be freed from their duties in order to tackle the job.

Dr. Long asked, "how do you find the human resources?" Dr. Griffith replied that you start by asking the advice of some logical person at a university. Dr. Howery suggested that the commercial consulting firms should not be overlooked. Dr. Griffith felt, however, that one should be very careful when

dealing with commercial consultants: that is, to watch for the consultant's bias as his firm is in business to make money.

Dr. Ossario suggested that perhaps we need to organize the universities' resources. "Or perhaps," Dr. Griffith stated, "we might be able to find graduate fellows interested in the mental health field who could do research in this area." The possibility of creating fellowships for mental health professionals to study adult education was suggested by Dr. Long. Dr. Griffith felt, however, that they might be too high priced and too scarce.

Dr. Long asked if there were any requirements for organizational change that were implicit in the organization. Can one, for example, work with a system where there are no basic skills without first developing these skills? Is there an example you can name where you could not get an educational program started? Dr. Griffith replied that a good example was his own failure to start communication and coordination between the board of education's literacy program and the welfare department in Chicago. It has not worked as yet.

Dr. Long wondered what the consultant should do when he knows he cannot to a full job, yet the organization still wants help. Dr. Griffith replied that he could not answer that in general. However, in the case of the welfare department in Chicago, he attempted to visit people within it and became involved in their programs on request. In speeches he tries to stress individual initiative and professional responsibility. He added a word of caution: one must work along slowly.

Group F

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RAQUEL E. COHEN, M.D.	C. H. WILLIAM RUHE, M.D.
ESTHER A. GARRISON, L.L.D.	HOWARD L. SIPLE, Ph. D.
HERBERT GASKILL, M.D.	DOUGLAS WATERSTREET
REX PITTENGER, M.D.	ROBERT TOBIAS, <i>Recorder</i>
DANIEL L. PROSSER, M.A.	VICTOR I. HOWERY, Ph. D., <i>Collator</i>

SESSIONS 1 AND 2

Learning Theory

The group started with the intent to focus on learning theories and educational methods but there was a general reluctance to talk about learning theory. In discussing this reluctance several of the members indicated that the reason is that learning theory is used very little in professional teaching and that most teaching and learning methods were evolved through trial and error. Clerkship learning in which physicians learned by reporting on what they were doing, discussing it, and then going back to apply new methods had evolved by this method. In nearly every learning situation both experience and conceptualization is needed. The need for doing (experience) was emphasized by many members of the group. Mr. Prosser emphasized the need for conceptualization for an intellectual framework. Dr. Ruhe commented that until the advent of George Miller's book medical education had been divorced from learning theory.

Motivation

Emphasis on learner motivation.—Mr. Rhodes brought the discussion around to the individual. He said that while societal needs are important we must concentrate on the needs, motivations, and rewards of the learner for success in any educational project, and that methodology must be related to the learner. Dr. Pittenger said that dissatisfaction or anxiety can be a primary source of motivation for physicians to participate in programs and that physicians will continue to participate in the programs so long as they feel their needs are being satisfied. It was felt by the group that this could be generalized to other professions and the question was asked whether an irritant could be provided. Dr. Cohen pointed out that most people have to learn before they become dissatisfied.

Mr. Prosser commented that another form of motivation for the professional may be an overwhelming sense of the pressure of circumstance and the realization of need in the community. This may cause him to look

closely at his professional field and see how it may be related to emerging needs.

Another motive suggested by Dr. Ruhe, at least for physicians, is that they recognize the rapidity of change and the need to keep up to date in a rapidly developing professional field. Dr. Cohen supported this with regard to psychiatry. Dr. Ruhe mentioned that the medical schools preach the need for keeping up to date.

The question of accreditation of courses was discussed. Dr. Ruhe indicated that many proposals had been made and that some inservice programs for physicians are now receiving credit.

The question of the age factor was raised in connection with motivation. Mr. Adams said that in his experience age was no real problem.

Mr. Rhodes raised the question of difficulties of finding the time and of traveling long distances to participate in programs. These are, he said, two real difficulties in the continuing education of teachers. Dr. Ruhe indicated they had done some studies on this in the case of physicians and that for short courses these factors had been found to be no real problem. He then asked what is meant by the attractiveness of a program. We must emphasize meeting the needs of the individual. Everyone is motivated to something. Too many programs are teacher rather than learner oriented.

Creation of a favorable climate.—The possibility of an institution, such as a hospital, creating through staff development programs, etc., a climate favorable toward continuing education was raised by Dr. Pittenger and the chairman. This was felt to be important in efforts to reach the individual who is usually a nonparticipant in continuing education. The interdisciplinary staff case conference was suggested as one way of stimulating a favorable climate as well as providing learning experience.

The Albany Medical College's two-way network program of inservice training has been successfully sustained and routinized. Dr. Waterstreet asked what percentage of physicians use this program, as studies in California and elsewhere had indicated that most health education activities were supported by only a small minority group of regulars and that the large majority were not reached.

The question of how to reach the nonparticipant was discussed. Dr. Pittenger felt that we cannot go beyond the nuclear group immediately. It must come over time. The question of whether it is essential to take courses in order to keep up to date was raised. Dr. Ruhe suggested that it is possible but more difficult to keep up to date without attending courses.

Experience of VISTA.—Motivation was not a problem, Mr. Adams said. If you have a good program in the sense that it meets the needs of those for whom it is intended, you will get the response. This has been his experience in many cases and notably in his work with VISTA. In these programs the deliberate attempt has been made to involve the teacher and learner in a complete situation. Welfare officers had gone to live in the families of the poor and had been given practical fact-finding assignments to develop

while they were with the family. Employment security officers had been sent out to look for work. Many of the volunteers for the programs had been from the lower socioeconomic level. Even where there had been compulsory attendance, as for bureaucrats, there had been a satisfactory response to programs which they felt met their needs. Mr. Adams thinks that we frequently overemphasize the factor of poor motivation as an excuse for bad programs.

Other Topics

Other topics, discussed and developed more fully in succeeding sessions, were:

- Who should be the targets of continuing education in the field of mental health?
- The need for an interdisciplinary approach to health education at all levels.
- The need for redefinition and expansion of medical roles.
- The organization and financing of continuing mental health education.

SESSIONS 3 AND 4

Distinction Between Target Group and Kind of Continuing Education

It was suggested that at least two different kinds of continuing education are needed for two different target groups. On the one hand, there are the needs of the professionals from the four core mental health disciplines—psychiatry, psychology, psychiatric nursing, and psychiatric social work. On the other hand, there is the need to educate further the so-called subprofessionals or aides.

The development of effective continuing education of the paraprofessionals and others not from the mental health professions was identified, however, as a major obstacle. The question was asked: Will professionals permit the factoring out of knowledge that has traditionally been uniquely their own?

Motivation

A suggestion that motivation might differ quantitatively in terms of the two target groups was rejected, but it was suggested that there was a qualitative difference. There was, however, some difference of opinion between those who felt that professionals were very highly motivated, in order to keep up to date, and those who thought that opportunities for continuing education and staff development were among the most important factors in maintaining staff at all levels. Studies were quoted to support the latter factor, and it was felt that this factor indicated the importance of continuing educa-

tion for the subprofessional. The low salaries of psychiatric aides was noted by Dr. Ray as being an inhibiting factor in their continuing education.

Suggested Methods or Techniques

Effective methodologies and techniques suggested for possible use in certain circumstances included the following recommendations:

- A greater effort should be made to use relevant published materials. Extracts of articles of significance to small groups with particular interests might be compiled to meet the need. In this way journals for paraprofessionals, for example, might be developed.
- More extensive use of television should be encouraged to present visual models of techniques, etc.
- Recognition should be given to electronic distributive techniques, i.e., radio and telephone, as important means of developing essential two-way communication.
- Group discussion rather than didactic presentation of material should be considered. It represents a method of learning in which there is emphasis on the full participation of teacher and learner in both the planning of the educational process and in developing the content.

The group elaborated on these points. The overemphasis on the lecture method was thought to be due to the familiarity of the lecture model.

Challenges for Continuing Education

Two challenges were identified for continuing education:

1. The provision of new knowledge, skills and in some cases, changes of attitudes for the subprofessionals concerned with the field and for professionals not directly in the field but related in various ways to it.
2. The accomplishment of an attitudinal change among the mental health professionals—an acknowledgement of the need to expand and redefine the medical model.

Mr. Adams in particular emphasized the need for a community-oriented model. To some extent the patient-oriented model was thought to be a rationalization. Dr. Cohen thinks that NIMH is closely identified with this medical model that needs to be changed.

Dr. Ray and Mr. Prosser both emphasized the need for parsimony in allocating resources. Dr. Ray indicated that there may be a danger in over-emphasizing reeducation. With the growth of population and the insufficient output of professional personnel there is need to utilize manpower in all fields which have contact with human problems.

Educational Tasks or Goals Redefined

Discussion centered on the distinction between two different tasks for continuing education. Should we take continuing education, in the context of this conference, to mean the inservice training and education of all

those in the field of mental health and those closely related or should we impose on continuing education a major task of social reform, the stimulation of communities to bring about change and reform?

It was agreed that the group was concerned with both tasks. Dr. Ray felt that continuing education could be seen as the avenue for problem solving and others suggested that education should be task-oriented. One task of continuing education, then, was seen to be the education or sensitizing of the power structure of the community. Dr. Pittenger indicated that the leaders of a community meeting in a regular seminar can lead to changes in a community. This had been indicated in the work of the Brookings Institution. The obstacles to change were recognized however and, as Mr. Prosser pointed out, change in particular is threatening both to the individual and to the community. The other task, mentioned by Dr. Cohen and Mr. Adams, is to increase the community orientation of physicians and psychiatrists, that is, to redefine the medical model. Mr. Prosser mentioned an instance in which this had been successfully achieved: through the influence of the funding agency an individual psychiatrist had been "educated" into first accepting and then recognizing the value of community psychiatry and making better use of the manpower resources available in the community through delegation.

Appropriate Resource for Training Programs

The question of the most appropriate agency for organizing training programs was discussed.

Mr. Adams indicated that during the past 10 years the Federal Government had given a lot of money to various universities to establish various types of training projects. This had been done in an attempt to involve the top experts. The money had thus gone to the traditional academic departments. This had been done in numerous programs and it had not worked. In very few instances had universities succeeded in establishing continuous training programs. They were research oriented rather than task oriented. They were not really interested in establishing sustained training programs. They were not geared to it. The money should, in his opinion, have gone either to the extension division or continuing education departments of the universities or to local agencies.

Consideration should also be given to the establishment or stimulation of new agencies in order to make new relationships possible. Dr. Garrison pointed out that some joint funding of the training institution and the agency perceiving the need might be worked out. On this point it was recommended that consideration should be given to funding the most appropriate institution for any particular program for any of the various groups that need it, e.g., inservice training of professionals, training of sub-professionals, training of professionals outside the field. Dr. Pittenger said that the initiative for any particular program may come from any agency

or institution and that there were considerable local differences in the university's concerns with possible programs. He stated that we could not say where funds should go in any particular case. The traditional NIMH approach of project funding was approved, but Drs. Siple and Howery emphasized the importance of full and early consultation between the agency perceiving the need, other local agencies, the university, and the Federal agencies. This should take place before program design had been developed and frequently even before money is granted. Dr. Siple stated that one common difficulty is that local agencies are aware of the danger of losing all initiative and control to the universities if they approach them at too early a stage.

Mental Health Services and Neighborhood Health Centers

Dr. Siple pointed out that the creation of neighborhood health centers raised the question of where the mental health component should be fitted. There was very little consciousness of the need for mental health services in these centers. He posed the problem of who should undertake the mental health duties in these centers and how should they be trained.

This raised two issues: First, the necessity for a redefinition of the role of the psychiatrist, which had already been discussed. Second, as the chairman and Dr. Siple pointed out, the boundaries between general medical services, mental health services, and other welfare services were breaking down. There is a great need for people from all these fields to get together. Mr. Rhodes indicated there might be a call for a new physical structure for all services that sustain people, including possibly education. Dr. Cohen cautioned that if we focus too directly on planning either services or programs in isolation, we may find that we are planning for obsolescence. Mr. Prosser emphasized that we must relate mental health to the other medical and welfare services. The chairman indicated the need for basic information centers to be included in any centers that are provided. He also pointed out the need for preventive mental health services in the family situation. Mr. Prosser emphasized this point and said that we must not wait for people to come into the clinics but go out into the communities, applying mental health knowledge and seeking the cooperation of all in close touch with human problems. Mr. Prosser then mentioned the difficulty involved in advising an architect in designing the construction of a mental health center at the present time. The only way is to provide space with a flexible interior. Flexibility is the essential requirement. Dr. Cohen underlined this: the only way to plan is to plan for change.

Mental Health Services and the Political Process

Dr. Ray emphasized the need for education in the political arena: the political answer to problems is to build a building rather than to tackle the real manpower and training problems of the present.

Dr. Siple, on the other hand, indicated that in some States the legislators are concerned with the establishment of flexible laws to meet the new needs of mental health services. Mr. Prosser said there was a need in many cases for a change in attitude within the professions in the field. There was a traditional prejudice against politics as being "dirty". We must however use the political expertise of the politicians and help them appreciate and use the expertise of the mental health professions. Dr. Gaskill pointed out that the communication process tended to be more effective in small States rather than big ones.

There was general agreement that every effort should be made to encourage regional planning groups such as SREB and WICHE to be conscious of the needs of mental health services and training. It was recognized that these bodies were already doing much good work and the establishment of similar bodies in other regions was to be encouraged.

Suggested Priorities for NIMH

In attempting to develop a system of priorities for the use of NIMH, Dr. Cohen made a tentative suggestion as indicated in figure 1. This was generally accepted by the group, although it was recognized that one must plan for change. There might be opposition from conservative professionals

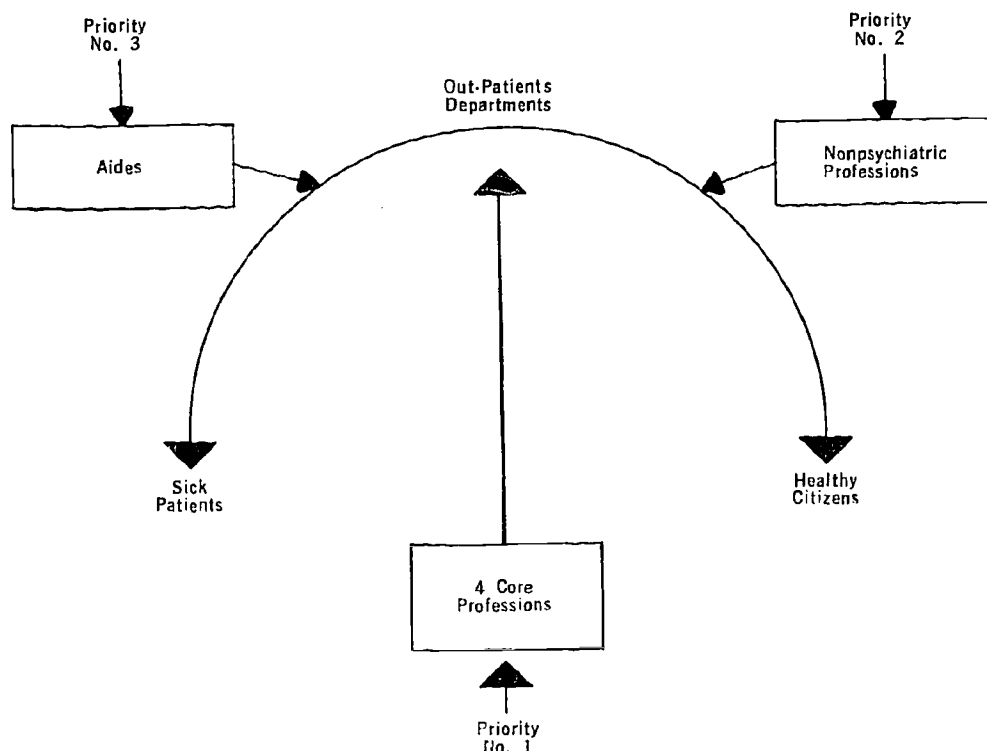


Figure 1.—SCHEMATIC PRESENTATION OF PRIORITIES FOR CONTINUING EDUCATION

to such a scheme, and we do not know yet what the effects of the establishment of the community mental health centers will be.

Further, although the nonpsychiatric professions are rated second in terms of priorities, their importance, particularly those of the physicians and clergy, was acknowledged. It was recognized that these are the groups that receive the greatest number of first referrals and that they play an important role as gatekeepers. It was emphasized, however, by Mr. Prosser and Drs. Pittenger and Siple that a misguided goal of continuing education is frequently seen in the attempt to turn the police and clergy into psychologists and social workers. The sanctions of these groups must be recognized as being different and there must be mutual respect for the individual in his professional identity in any training programs.

Mr. Rhodes suggested the NIMH should hold more conferences such as this of all those concerned with human problems and that it should disseminate information about new techniques in continuing education to the field as a whole.

In attempting to synthesize its thoughts on the last 2 days of the conference the group attempted to identify certain broad principles which NIMH might use in framing its policies and certain broad groups, or target groups, for whom continuing education programs might be planned:

GOALS:

1. Develop interdisciplinary approaches in training among core professionals.
2. Encourage regional cooperation and additional planning groups such as SREB and WICHE.
3. Identify national leadership groups and individuals.
4. Provide diversification and flexibility in program formats.
5. Develop cooperative activity with the field of welfare programs and training.

TARGET GROUPS:

1. Interdisciplinary professional mental health groups.
2. Nonprofessional personnel directly concerned with the field of mental health.
3. Nonpsychiatric professionals—doctors, lawyers, clergy, teachers.
4. New types of mental health personnel.
5. Community leaders and/or politicians.

SESSION 5

Identification of Power Structure Within a Community

The group accepted within its terms of reference the discussion of continuing education for social action. One task then was to identify the power

structure. After discussion it was accepted that the nature of the power structure varied from State to State. In some States power appeared to lie in the acknowledged community leaders. In others, action seemed to come from the party political structure. In all States, however, the importance of the top administrators, particularly those in charge of finance, was recognized.

Planning on a Regional Scale

Dr. Siple stated that there was a disconnected view of planning for mental health between regional, State, and local levels. Sometimes the planning was effective and sometimes not. He suggested the possibility of NIMH making grants to States to consider health and welfare activities and training. It was reported that this had been done on a regional basis. Dr. Garrison pointed out that there is a difference between making grants for planning per se, which NIMH has done, and making grants for the planning of educational programs for carrying out plans. Mr. Prosser commented on possible political overtones to the training of policymakers. Dr. Siple, however, felt that the funds could be made available to the States without any form of dictation. Dr. Gaskill indicated that WICHE and SREB have been doing this type of thing for some time on a regional level and, further, that the amount of change in Colorado over the past 10 years has been fantastic. Of course, as he also pointed out, the South and West started from a lower socioeconomic level. Dr. Ray emphasized the need for regional structures such as these to be more widely recognized, in terms of their social function, and institutionalized. He felt that NIMH should assist such bodies even more than it has done.

Need for Training of Public Administrators

A need for training on a broad sociomedical level for top administrators at the regional level was expressed by Dr. Siple. Drs. Gaskill and Ray agreed and further suggested that there was a need for this at the State level as well. It was again stressed that the emphasis must be on the top administrators. Dr. Webster suggested that institutions with experience in training public administrators, such as the Brookings Institution, might help develop such programs. Mr. Prosser suggested that NIMH should encourage States to send top administrators to sensitivity training. Dr. Garrison said that it might be possible for NIMH to hold a series of conferences.

Cooperation at the National Level

The need for close cooperation between organizations at the national level was emphasized by Dr. Webster. The need for a greater degree of collaboration between granting agencies, as boundaries overlap, was also

emphasized. On the other hand, there is a danger in this that one segment of the field might lose out financially. As Dr. Siple pointed out, mental health does not want to find itself in competition for funds with such projects as clean water and clean air.

Evaluation

The subject of evaluation was discussed as it was recognized that, in any competition for funds, an evaluation of the effectiveness of programs of continuing education in mental health is crucial. This was recognized to be a critical issue, since true evaluation, even where it is possible, is very expensive.

Group G

LEROY W. EARLEY, M.D., <i>Leader</i>	ROBERT SUTHERLAND*, Ph. D.
JOSEPH J. BAKER, M.D.	W. CARROLL WARD
JULES PAGANO	JOAN E. WALSH, M. Ed.
RODNEY PRESTWOOD, M.D.	NAT T. WINSTON, Jr., M.D.
PAUL H. SHEATS, Ph. D.	LILLIAN DAWSON, <i>Recorder</i>
RALPH SIMON, Ph. D.	C. L. WINDER, Ph. D., <i>Collator</i>
RUTH SMALLEY, D.S.W.	

SESSIONS 1 AND 2

The opening question presented to the group was: What are the objectives of continuing education? Dr. Sutherland commented negatively on the morning session as an example of what *not* to do. He said it is necessary to get away from such wornout phrases as adult education and continuing education and to develop more interesting programs and ideas. The Jaycees, in his opinion, have developed a fresh approach to involvement in learning.

Selection and Development of Personnel

Dr. Smalley noted that one of the speakers said that facts and knowledge are multiplying rapidly, but that he also asked what kind of man is being produced? Not only what he should know, but what kind of a person he should be. We must develop a concept of what man is to be and develop programs to make him the way he should be. We have to develop a new concept of programs.

Dr. Simon added that the speaker had touched on the difference between training and selection. That is, should we be more concerned with training or with selecting the right kind of people? What use are models of other people? For example, take Goodman's work at Berkeley on selection; he points out that we must improve our skills in selection as well as training in order to get the kind of man we want. Dr. Prestwood expressed his belief that there is too much concern with teaching technique and not enough with learning. The personal touch is lost in training. There is a tendency to be overcome by techniques rather than to concern ourselves with humanizing factors in continuing education. Dr. Simon added that one constraint that has led us in this direction is government and business involvement. Technology is emphasized; jobs are too tightly defined; and training courses are too rigidly controlled. In the professions where personality and judgment are required, teaching is still being geared to the technology instead of the personal qualities that are needed. But some people,

* Group leader session 5.

Dr. Earley said, want only technical training and not an education. If you remove the technical props, Miss Walsh asked, how do you assess needs and skills?

Dr. Winston commented that continuing education seems to continue a system that is not very good in the first place. He suggested that perhaps we are faced with the need to reassess roles. He noted that many "sick" people are involved in the mental health profession, and suggested that we need to look critically at the kinds of people that the educational system is promoting. Have we allowed technical devices and procedures to select people who should not be in the mental health field or in education? Just because a person has a degree does not mean he is qualified. Dr. Earley pointed out that the four core professions in mental health did not originally require a degree; and that we must protect the professions by requiring the necessary education and training.

Dr. Prestwood commented that the speaker at the morning session said that technical training becomes obsolete in 5 years. If this is true then the education of doctors is obsolete along with the rest. However there is a difference between doctors as technologists and doctors as humanists. A doctor will never be obsolete if he is able to learn and is a "good" person. This raises the question of why only 15 percent of physicians participate in conferences. If men are to be life-long learners and human beings, they will have to continue technical training on their own and opportunities will have to be provided to them. Dr. Earley asked whether he was saying that physicians engage in more self-education than other mental health workers. Dr. Prestwood replied that doctors in hospitals do better because they face group pressures. Lawyers do better because they are in the public view and are forced to keep up with legal developments. However the professional mental health worker often works in relative isolation or as a member of a team that knows little about his specialty. Dr. Simon added that one example of this is medical training where psychologists are not solicited to teach courses in psychology, the assumption being that psychologists tend to be independent and run their own courses.

Dr. Sheats suggested that one of the problems implicit in this discussion is the matter of finances. Legislators seem to think that training should be self-supporting because professionals gain from it. Legislators must begin to realize that society should be willing to pay for this education for society reaps the ultimate benefit. Moreover, in the mental health field, many of the professionals cannot afford the cost of continuing education. And too often such education, if offered, tends to be a package deal instead of encouraging individual learning. It fails to touch the problem-solving approach which would involve learners.

Dr. Smalley said there was a parallel in social work. Class work provides the background for field work; and work in one area contributes to the other.

Encouraging Involvement

Dr. Earley mentioned one experience in problem solving in Pennsylvania. When they got through, the community ~~did not heed the suggested~~ solution. So it is also a matter of being willing to ~~accept~~ the solution which is the result of the problem-solving process.

Mr. Ward said that there doesn't seem to be enough coordination between what is being done and what needs to be done. There needs to be better feedback. The State people do not relate to local groups. Moreover, there needs to be more involvement with child retardation rather than mental health. Projects of lay groups are too big; they need to be pared down to manageable size. Dr. Earley felt that the issue is not failure to get support for programs in retardation; rather it is concern for the fact that legislative committees do not understand the problems or rely only on professionals for advice. Mr. Ward added that there is a need for public relations men to sell good programs, not only to legislatures but also to the public. The public really does not know as much as professionals think is known.

Dr. Prestwood suggested that involvement requires that the professional first recognize the learning need within himself. Dr. Earley asked how we get the disciplines in the university or in agencies to work together. Dr. Simon replied that Dr. Kraft at Fort Logan found that it was not easy; the disciplines had to figure out how to work together before anything could be accomplished. Selection of personnel committed to cooperation is one way to insure working together. He then added that if the disciplines are brought together for training, what do you train them in, what dimension do you use? You can go in one of two directions: either you can group the four disciplines together around a common subject or teach each of the subjects in each field.

Dr. Earley added that communication takes time but by working together you learn to discuss the kinds of differences that we have been talking about.

The many levels of interdisciplinary action were pointed out by Dr. Sheats. He added that we have much success already at all levels, from top professionals to subprofessionals and volunteers. However, he believes that in random groups the task is to decide what disciplines should be included. In group dynamics in Lewin's day, the early 1940's, the participants wanted to get in on feedback sessions; possibly this is applicable to this question. However, Dr. Prestwood said he was not so sure; evaluation sessions usually skim the surface and do not involve people in a meaningful response.

Dr. Earley remarked that in his early days, when he was circuit riding in Michigan, training professionals in remote areas, he found that the wives of the psychiatrists wanted to know the same things that their husbands were getting from the courses. Dr. Prestwood added that several

years ago, in a program in Oregon, they got the whole community involved. The community agencies were asked what they wanted out of the experience and asked to provide equipment and instructors, etc. They had a terrific turnout and support. Dr. Earley asked him how they established their contacts? He replied that they had built them up over the years, and that they felt that they were actually filling a need.

Dr. Simon noted that many programs meet initial resistance and asked what do you do then? Dr. Prestwood answered that they had one individual who gave trouble. They got him involved and developed a liason with him. Now he is one of the best supporters of the program. So many experts go to a community and just lecture. They do not ask the community what it needs and therefore never attempt to make the program relevant.

Techniques and Continuing Education

The topic of techniques, including the use of TV, was raised by Dr. Earley. Dr. Winston replied that he thought TV is underused and underestimated. Mr. Ward added that it needs to be used in more creative ways. The best tapes should be available and interesting techniques used; but most importantly errors in presentation should be cut down and the latest information presented. Unfortunately, Dr. Prestwood noted, there is a tendency to do on tapes what is done in other media. If TV tapes have special merit, why is not something being done to maximize the contribution? There is not much point in reproducing a method which is already deadly dull.

Miss Walsh asked how we can get around the authoritarian approach in teaching. Dr. Smalley commented that the technique must be appropriate to the goals of the program. Dr. Earley urged that not all of the old ways be disregarded entirely; some of them have been very effective. Perhaps, Dr. Smalley said, we need to make the tapes and other techniques more professional. Commercial companies make good use of professional actors to drive points home and those actors do not need to have a real understanding of the lesson. Dr. Sheats added that he had seen some films on law that are excellent. And there are films like "Three Faces of Eve" that have been used successfully and extensively. Dr. Earley said that he had seen some good amateur films made by students and professors. These pull in the students and force them to look at themselves and at each other. Everyone gets in on the project; it can be very constructive; no one feels picked on. It was pointed out by Dr. Simon that many places are loaded with equipment but it is poorly used. Dr. Earley agreed and added that inasmuch as the equipment is expensive you have to be sure it is used to the best advantage. The job however, can be done without equipment; the teacher is more important than all the gadgets in the world.

Other Elements in Effective Continuing Education

Dr. Earley brought the discussion back to the issue of what is effective in continuing education. He reported that he tries to teach small groups in the hospitals but it never seems to work. They don't respond. Perhaps, Dr. Prestwood suggested, competition is a problem; competition between the professional groups and different levels of groups.

The case method of presentation seems to be effective, but the primary problem is with lectures because the participants are not involved.

Dr. Winston noted that it is surprising how much responsibility people, even volunteers, can take. Dr. Prestwood noted that during his professional training, volunteers just didn't or were perhaps not permitted to take responsibility.

Dr. Sutherland reported on a study done at the University of Chicago where an attempt was made to interest school consultants in further training. A weekly seminar was held; and each participant selected for study a child whom he thought was normal. The seminar proceeded with the task of finding out about a normal child's behavior rather than studying problem children. This turned out to be an excellent inservice training program because it dealt with everyday problems. Normal children turned out to be very unique individuals with complex problems. This experience proved to be stimulating and enriching.

One thing we need to remember, Miss Walsh said, is to show respect for what the participants already know. If you start with what they know, you can build on that to help them recognize areas where they are weak or totally inadequate. By that time their confidence is supportive. Dr. Simon agreed: some inservice training is so threatening. The question is, how can we cut down on the threat. Many of the professionals are "gods" in their communities or hospitals. It is important not to degrade them, yet very often this is exactly what happens in unplanned offerings.

Dr. Earley noted that it appeared that learning blocks are the biggest problem. There is also the problem, Dr. Smalley added, of overlapping between agency and university involvement in education programs. The university tends toward broad general education, while the agency tends to concentrate on specialized skill training. Dr. Winston said that he did not think that the problem is as great as suggested. He thought it was more a question of the professionals thinking of themselves as competent and not needing any training. They fool themselves and bluff their way in lay and professional circles. Dr. Earley commented that attitudes among mental health professionals seem to be worse than in other professional fields.

The question of how sensitivity groups are used was raised by Dr. Sutherland. Dr. Winston said he believed they are used extensively, but there are differences in the way the term is used. Dr. Sheats said that sensitivity groups were not originally used for therapy but were used in problem solving and task-oriented groups. Now there is a bit of confusion as to their purpose.

Also there are positive and negative feelings about sensitivity training that have developed over the years.

Mr. Ward reported that in a conference in Denver where Jaycees from across the country talked about problems of mental health a bit of sensitivity training was used. Because the participants were carefully involved, this turned out to be one of the most stimulating conferences he has ever attended.

It was reported by Dr. Winston that in running their programs they have learned several things. Lectures tend to be boring but tours of the hospitals, etc., have aroused great interest. In the discussion sessions the earlier exposure to the facilities did much to get the groups talking. There are plenty of ways to get to the heart of the matter besides lecturing.

Dr. Simon said that you lose many people by trying to inform or teach people before they go into a discussion session, like this morning. Let learners work before you try to teach them theory. Dr. Earley stated that the example might be restated: We put personnel in the wards first and let them face patients and problems. Miss Walsh reported that they had tried this procedure with nurses. It decreased their spontaneity at first but it came back. They were put in the hospital with very little instruction; but the instructors tried to help them individually and as a group as they went along.

SESSION 3

Responsibility for Developing Continuing Education Programs in the Mental Health Field

Dr. Earley stated that the deans of medical education are willing to go along with the idea of continuing education as long as they do not have to take responsibility for it. Whose job is it anyway?

Dr. Smalley said that it is hard to look at the total program and break it down into its parts. One solution could be a series of noncredit courses or possibly a degree program with some one person in charge, like an extension program.

Dr. Earley pointed out that it is already difficult enough for medical schools to maintain themselves, due to the expense of equipment, etc., and it is even more difficult to provide a continuing education program unless it has special support. Dr. Sheats said the public institutions are up against the same problem in trying to provide educational programs. There is always the problem in finding the support of professional groups. For example, law supports itself but welfare groups cannot. It is generally assumed that the student should provide for his own further education but this is not possible on salaries such as are paid to most welfare workers. Ways of getting financial support from local boards, etc., must be found. There has not been that kind of support and as a result public institutions have not been

able to provide the continuing education programs that are needed. It is a case of the "haves" getting what they need because they can afford it.

Dr. Smalley said that there is money now, Federal and State. Proposals can be submitted for worthwhile programs. Basically, however, the institutions have to find the means to support good programs; and most institutions do not make any profit on such activities.

Dr. Winston reported on a program in his Center that makes money and has been able to build up a small nest egg for special educational programs. He is not sure who should be responsible for educational programs generally—the clinically or analytically oriented. General practitioners could empty our hospitals if they had a little more training, but they must be approached from a practical standpoint. Too often academic people do not relate well to the practicing doctor. Dr. Earley commented that Dr. Winston has developed a good continuing education program in Tennessee and asked about the junior college system that is beginning to be developed in most States. Dr. Winston said that they cannot wait for the junior colleges. They are already selecting sub-professional mental health workers in their programs and teaching them some theory and making group leaders out of them. They use professionals only as consultants. The group leaders can be used to coordinate programs and do some of the tasks that professionals previously performed.

Dr. Sheats said that his group had been approached by the city of Los Angeles to train citizen committees to inform the public. Unfortunately, they cannot finance this. He asked if there were any Federal grants available for this sort of thing. Dr. Simon replied that there were but it would have to be identified as a model program, and asked if he anticipated that the program could be developed as a model. Mr. Ward said that it is a form of continuing education.

Dr. Winston reported that a local program in his area provided a 1-year training program for college students who wished to be mental health workers. Philadelphia has a similar program of training young people to work with mental patients; it is an extension of their education. The program is focused on employees called social therapists. We are or should be training new kinds of people for new types of roles. Unfortunately, Dr. Simon said, credit cannot be given for this kind of program. Dr. Earley asserted that education needs to lead people into new fields of interest instead of being irrelevant to any or all interests.

Another possibility, mentioned by Dr. Sheats, is combining Office of Economic Opportunity programs and junior college programs to train mental-social-health field workers.

Definition of Continuing Education

Miss Walsh suggested that the group needed to define continuing education for its purposes. Dr. Sheats said it could be described as any education

beyond high school. Dr. Winston said, however, that there is confusion between professional and personal continuing education. Dr. Simon agreed and said it could be defined as relating to any person who wishes to further his education in a profession; but there is also education with a different emphasis, over and above professional training, as for example the nurse who takes additional training in the field of hospital administration. The latter type of education is not recognized by NIMH in terms of funding projects. Money is currently provided in three categories only—professional, general, and specialized education. Unfortunately the funds requested must somehow be made to fit into one of these categories. Dr. Sheats said that this differentiation is unlike that usually made in extension divisions of a university and therefore can create misunderstandings.

Obtaining Funds

Dr. Sutherland pointed out that there are possibilities of securing private foundation money. He reported on a program planned to help families with decision making, using counseling and enlisting the aid of the family service agencies, which provided matching funds. They found that the foundations do not want to be told what to do with their funds, so a plan was devised to educate the foundations and, incidently, the program planners. Representatives of the foundations were invited by the university to educate them. In the process, the foundations saw that there were real gaps in their continuing education programs. The university also found out what the foundations were interested in and that they, too, have limitations in their interests and funds. The same method could be used to reach other decision makers, like legislators or the people who hold the money. Dr. Sutherland, when asked to be more specific about his procedure, replied: (1) Invite three or four legislators and ask them to tell the university people what they believe the future of the State to be, etc. Find out what their interests are. (2) Bring them together with politicians from other States where there are good programs and good support. Eventually the talk will get around to the differences between States; and the views of the more sophisticated legislators will rub off on the less sophisticated. (3) Interest developed would hopefully result in questions on research and programs being asked. Mr. Ward noted that the Jaycees have done this in Georgia. They conduct State and national seminars to which legislators are invited. Dr. Simon said that the reverse can also happen. Sometimes legislators will arrange for staff educators to go to their States and talk about mental health programs. It can work both ways, with both groups of professionals becoming better educated concerning the problems. There is a problem of identifying federal funding sources to determine what program "fits" and what doesn't.

Dr. Sutherland pointed out that there is a possibility of getting partial support from private funds, as in the program he reported.

Extension Programs

Miss Walsh asked whether continuing education programs should be separate from extension programs. Dr. Sheats replied that in California the two are tied together, but in some other States they are separate. He favored an integrated program because you can then use the expertise of professionals in generalized education.

Dr. Prestwood asked if there are arguments on the other side. Dr. Sheats replied that some people feel that the continuing education program should be integrated with the normal teaching load of the various divisions. In that case the continuing education program in each department would be included in the department budget. Some experts feel that they cannot logically be divided.

Dr. Sutherland then asked if extension can work with the separate divisions on their own ground. Dr. Sheats replied that the more you divide up the problem, the less you see of its total dimensions. You begin to see the university as being unimportant in solving large State or comprehensive problems. You forget that it has a place to fill just because it has become so fragmented. It doesn't make sense not to use the expertise of the university.

Mr. Ward said that it appears that groups that can afford to pay for them get the services of the university. Unless there is some coordination among the professions for educational programs, in the extension department, the poorer professional groups are likely to be left out.

Dr. Earley asked if business and industry come to the university extension division for help with their programs. Dr. Prestwood replied that they may come too often, with the result that there is competition for the services or, worse, overlapping of services. A certain amount of coordination is necessary. Dr. Sheats added that the Federal Government can insist there be no overlapping among groups coming to the Federal agencies for money. Proposals are sometimes sent back if it appears that they would be in conflict or competition with others. Dr. Winston added that the different needs of different groups should not be ignored and to wrap them up in one overall program could be disastrous.

Dr. Sheats commented that the burden of coordination should fall on the State, but seldom does. When there is decentralization there are apt to be too many gaps.

Dr. Earley noted that in Pennsylvania there are many areas and groups that are left out of good programs. Still, Dr. Winston said, an overall program must allow the separate groups to have an identity and to belong to a region of its choice.

A question was asked: Why isn't the expertise of the educators, especially the extension people, used in developing programs? Dr. Earley answered that the history of education has prevented it. Only recently have educators

had anything to offer other professional groups. They have not been called on because people have an obsolete image of education. Dr. Smalley added that the professional groups also want to be sure that they control the programs, especially the quality of the information that is taught. Often they feel that they are best qualified to handle their own educational programs.

Dr. Simon stated that we need to go to the extension people and ask for help. Dr. Winston added that we can learn a lot from industry which is assuming an important role in education; they are doing a lot of it. "And," Dr. Sheats remarked, "why not, if the established institutions are not doing a good enough job? Industry could well take over. Many task forces do a good job. Perhaps they need an overall plan, but they have a strong point—efficiency." Dr. Smalley remarked that efficiency has to be related to a goal. Many ways to do things may be needed, even if some of them are relatively inefficient. Dr. Sutherland pointed out that industry isn't flawless. It spends and wastes a great deal of money. On the other hand, education has done remarkably well on very little money. He also expressed impatience with task forces made up of bright young men with little experience or insight, who prepare impressionistic data, and come up with shallow results which they then release to the newspapers. They may actually do more harm than good, though perhaps they may act as a stimulant and prevent procrastination on the part of professionals and educators.

SESSION 4

Continuing Education and Community Mental Health Agencies

Dr. Earley asked how the many different elements of a community mental health agency can be brought together. There is a mandate from the Federal Government to train several kinds of professionals. How can we determine what programs belong in university programs and which may belong in agencies such as community mental health agencies?

Dr. Winston replied that he felt that the big problem is drawing lines of authority within the established agencies and divisions. Dr. Earley added that there must be a change in attitude towards centers trying to provide programs; although it is hard to know what to do in community center programs; Dr. Winston questioned whether it is best to build completely new and independent programs or coordinate programs within existing structures.

Dr. Simon said that five essential elements are required in the development of community mental health centers; one is consultation. He noted that new programs sometimes leave out some essentials. He suggested that the centers should also serve as a training laboratory.

In response to the question, "What is being done in California?" Dr. Sheats reported that the centers have been useful as part of the programs in extension education.

Expanding Programs Into New Areas

Dr. Prestwood asked how you set up programs for many different kinds of people and problems. Dr. Smalley asked if you develop new disciplines or train a new type of mental health worker. Dr. Earley said that it seemed as if we must since there are not enough to go around and because there are not enough professionals. We need something in between.

Dr. Sheats suggested that citizen action committees ought to be interested in all sorts of professional centers, with groups to tackle various problems. Dr. Earley replied that sometimes the groups do not seem to be related. He suggested the need for a different type of professional than we now have. At present certain problems are almost untouched by the professional disciplines, problems such as mental health and school success among children under 5 years. There are not any "pros" in Headstart in Pittsburgh because there aren't any professionals who understand that kind of problem. Dr. Sutherland suggested that preventive mental health programs be discussed. He noted that there are summer enrichment programs for elementary children; they learn to function better in the school atmosphere. This has turned out to be a meaningful experience for the children.

Dr. Winston said that we do not know very much about preventive psychiatry, partly because one cannot know in advance whether a child or adult is going to be sick. Dr. Sutherland suggested this matter be tackled from another viewpoint. He asked whether there were more or fewer cases of mental health problems as a result of the community OEO projects? Dr. Simon replied that it is hard to tell because one does not know how many there would have been otherwise; and because the people at this social level move so frequently in and out of the area and the programs. Dr. Earley pointed out that it is not possible to do effective studies in this area as in communicable diseases.

Dr. Sutherland suggested that one of the principles of prevention be used; that simple tasks be taught which, if accomplished, make the individual better able to cope with the world.

Dr. Winston remarked that perhaps one reason why our patients stay in hospitals for such a long period of time is that we try so hard to keep them in. In one study, the group which was encouraged to stay actually had a much higher percentage of dismissals than the ones who were encouraged to leave. Dr. Smalley said that she had experienced opposite results. A high percentage of patients who were out on their own with the aid of a social worker, made a successful transition. It would appear that the result depends on the definition of success. Is the goal to keep beds filled and let patients live or exist, or is it to make them self-supporting and contributing citizens? There are plenty of programs which do the former. Limited evidence shows that where there are more facilities and personnel available, we seem to have more patients. This suggests that perhaps we are coddling some individuals. In foreign countries and in communities which do not have the facilities, the patients seem to manage fairly well

without extended treatment. Dr. Earley noted that he has also been tempted to suggest that some people produce the symptoms as a result of too much clinical treatment.

Dr. Simon mentioned one study of expatients who were sent out to work in ordinary jobs where other people did not know that they were patients. They did not show symptoms while they were working but did show symptoms upon their return to the hospital. Could it be that we "make" patients? Dr. Sutherland said that the Hawthorne experiments showed this to be true.

To a question about implications of this discussion for continuing education, Dr. Smalley commented that she believed the necessary skills and knowledge are available to develop programs in new areas including preventive.

Developing Leadership

Dr. Earley then asked if we had proof of the ability to develop and extend leadership skills. Dr. Smalley said that various methods to extend leadership have been tried. Social workers and "certifiers" in the field of welfare have been classified according to leadership skills. However, it was discovered that the clients did not understand why they had to see two types of workers to obtain a grant. The crossfire was great. Certifiers were not qualified or did not have authority to answer certain questions, while social workers sometimes found themselves doing the job of the certifier. The workload had to be changed. She noted that it is hard to make a distinction between levels of performance. An element of judgment is always involved and a nonprofessional cannot always be used.

Dr. Sheats asked if there is resistance to nonprofessional workers among the professionals. He reported an experiment in a small town in which team teaching was used with various kinds of people on the team. It worked well, and insights were strong among the nonprofessional people on the team. Mr. Pagano suggested that we have not thought enough about levels of education; we tend to look at the subject too narrowly.

Dr. Simon asked whether we were in a position to talk about who should have responsibility for a continuing education program. Dr. Earley remarked that one of the worst mistakes is to begin a program and then have it fail because there is not enough personnel or money to see it through. Dr. Sheats said that this is the point where an extension division can be useful. If a training official is made available it is probable that he will be used. But it is up to the professional groups to make one available.

Dr. Winston suggested that the professional could perhaps begin a hyphenated position; he could take on the extension assignment as a part-time responsibility along with responsibilities in another department or agency. Mr. Pagano speculated as to whether the development of such a position would bring about an increase in quantity and quality of training. Dr.

Earley remarked that they had a competent director who developed many programs but when he left the contacts he had made with the State hospitals were lost. Professionals within the disciplines have been used but perhaps an educator could better function in this position.

Dr. Winston asked how such an individual would be used in connection with subject matter directors. Miss Walsh replied that this individual could work with the specialists, developing programs around material they thought was important. Resistance on the part of service directors is sometimes found but Dr. Smalley said a framework exists within which it is possible to work: it simply has not been used enough.

Dr. Sutherland suggested that perhaps we have built up a system of roles which encourages competition. Dr. Smalley thought that there was something more to it; a feeling of responsibility toward the subject. Dr. Simon stated that you have to be careful on whom you operate. There is some professional jealousy, for example, in the hospitals among nurses, practical nurses, physicians, and administrators, etc. There is always a certain amount of competition; and an educator would have to allow for that in building a program. Dr. Sheats suggested that it is useful to pay attention to the process itself. Some program directors are able to take advantage of the time spent together while others are not. If the group is working well together (process) its success is greater. Mr. Pagano, however, had some doubts; he noted that some people perform better in the face of competition and anxiety. He also pointed out that some programs have been able to avoid institutionalization while others have become bound up in it. He cited HEW as an example of a rigid structure.

SESSION 5

Training Programs

Dr. Sutherland raised a series of questions about developing programs in continuing education.

- What proposals should be made?
- Should a regional plan for training be developed?
- Should regional conferences be set up?
- Is a special State authority needed to administer or help programs?
- Would it be possible to get support from the State commission on mental health?
- Is it possible to build a training program as part of a community mental health center?
- Should advisory review boards be established with responsibility to see that training functions are properly undertaken?

Dr. Prestwood reported that in California a grant was made for the specific purpose of gathering data about the need for and availability of personnel for mental health programs. It was felt to be important to ascertain the facts

before developing a program. Research about the communities must be done before universities begin to develop programs.

Dr. Sutherland suggested three policies with reference to developing applications for grants:

1. Gather facts about the needs in the community,
2. Survey the resources of the university with reference to these needs,
3. Propose ways of retooling facilities and resources in order to meet the needs.

Dr. Smalley said that the Council on Social Work Education has undertaken a nationwide study of social work needs and resources in continuing education. This is very important; before developing plans of action, we should find out what has been tried in other areas. With such information in hand, the council can develop guidelines for more effective projects.

Dr. Sheats suggested that this might be a function for national associations. He asked whether such associations could be persuaded to review programs and provide guidelines; such efforts could in turn strengthen the professional associations. Mr. Pagano said that the NUEA is a case in point. Its role has changed completely as a result of one of its special projects. That project used the association to span the entire field of adult education; the target was the elimination of illiteracy. The first step was to see what programs and people were at work, and to evaluate these activities in terms of future programs. This was done by means of a conference. Areas of need were pinpointed; and people were assigned to hold similar regional conferences. This project is carried on by the university, not by the Government, although it is an HEW project. In the first year, grants were made for the training and evaluation in order to rally professional support. During the second year, a professional person was provided for, to carry out the program in each region.

Dr. Sheats added that one of the problems that the NUEA program hopes to lick is the here-today-gone-tomorrow character of most Federal programs. Often the university or community is left with nothing after a whirl-wind Government program has ended. The program uses existing university personnel and hopes to guarantee continuing interest beyond the term of the grant. Dr. Sutherland pointed out that this idea is applicable to the mental health field and suggested that perhaps a start could be made through the National Association of Mental Health.

Mr. Pagano said that another funding source is OEO, through which multipurpose training centers have been developed. This is being done in some places for the CAP program but could be expanded to include the mental health field. The idea would be to provide unified training programs for several levels of workers, combining the resources of NIMH and OEO. Dr. Sheats said that one fault of many OEO programs was that the funds went directly to the university to fund training centers which were not tied to any of the professions. No one professional group felt responsible for the continuance of the program.

Dr. Smalley said that an up-to-date survey is needed of training programs in mental health all over the country at all levels. Perhaps a grant application should be submitted for this purpose. Mr. Ward said that some States and regions have more projects and receive more grants simply because they have better grant application writers. Dr. Sheats asked if it would be useful in Georgia, for example, to build up continuing education at the State and local level to follow up on the Jaycees national seminars. The money could be used for regional or community meetings and for materials, etc. Mr. Ward replied that all these things are being done. The NIMH required them to put down in black and white precisely what they were going to do. The grant was for a large program; in addition to the seminar in Denver, to which PTA and other lay groups were invited, it provided for State and regional meetings and for developing a State leader's handbook and pamphlets, etc.

Dr. Sutherland reported that this group seemed to have identified several factors about funding.

- There must be fact gathering first,
- Groups and resources must be used relative to their potential;
- It is necessary to find out what is being done all over the Nation,
- It is important to include national professional organizations in plans for grant applications to NIMH.
- Attention should be given to the multipurpose training centers.

Regional Organization

Dr. Sutherland then asked the group whether NIMH should help establish regional offices with materials and personnel as resources to which lay groups could go for help. Should there be regional adult education specialists?

Mr. Pagano suggested that there would be limitations if such programs were established in the Federal structure. It would be better to establish it in institutions of higher education. However, he added that we need a new kind of institution capable of dealing with long range as well as short problems. What is needed is a consortium, combining the resources of universities, national professional organizations, community citizen groups, State mental health authorities, and regional NIMH officials. Examples of such an institution are WICHE and SREB. It might be a good idea to find out how they operate, of course. However, there is the possibility that the various components would be too busy to be interested. But perhaps a grant could be secured so that an organization like WICHE could explore the possibility. A question was raised concerning whether the groups to be involved at all levels would accept such an idea. The consortia are likely to represent most heavily higher education institutions.

Dr. Sutherland asked whether it would be possible to obtain a recommendation for a State level operation now? Dr. Sheats replied that there is no lack of machinery as far as organizations are concerned, but there is lack

of ability to use it effectively. He questioned whether it was not time to do something from the bottom up instead of from the top down.

Dr. Prestwood suggested that the feasibility of regional meetings on various tasks be explored. The regions which vary appreciably should be able to express their individual needs; and a blanket plan could not allow for these differences. The "chicken-egg" problem involved makes it difficult to say whether a regional program should come first, in order to build the national program; or whether a national program should come first and then be broken down into various regional programs. Actually either unit could initiate the meetings. One defect of the regional plan, if too narrowly defined, is apparent in the relative weakness of some areas. For example, California and Pennsylvania have strong programs and surrounding States can hang on to them to a certain degree. Of course, the strength of a program varies with the director who may be stronger or weaker. In either case, we need to protect certain areas at certain times by providing a comprehensive program in training.

Mr. Pagano commented that one requirement of HEW projects is that organizations and agencies must be represented on the advisory committees. He noted and agreed with Dr. Prestwood's recommendation that agencies and committees be represented on the board, so that the power structure of the region or locality be used. They must touch base with all the organizations to insure adequate support—even in the preliminary stages. This guarantees communication among community groups before a project is launched.

Problems in Evaluation

Dr. Sutherland posed questions about evaluation. Dr. Smalley said that measurement is very difficult. First, there must be a sharp definition of goals and clear decisions on methods of working toward those goals. The evaluation must be made in relation to the goals. Mr. Pagano suggested sometimes it is best to call on some committee to review the work of the project, so that progress can be earmarked. However this is not the same as a critical evaluation. Perhaps process recording should be included in the request for a grant. A review of the process must be made at intervals. At the end a formal evaluation should be made. However, rigorous research type evaluation should be made only under certain conditions. The kind of evaluation that is made must be appropriate to what is being evaluated. There must be an attempt to look at what went on during the project as well as its outcome.

Dr. Prestwood added that evaluation involves more than quantification; there should be multipurpose evaluations. There are also different levels of evaluation. He further suggested that there seems to have been confusion

as to the type of continuing education participation this conference group is talking about.

Dr. Sutherland suggested that the term should include all professional, paraprofessional, voluntary, and lay groups working in mental health; it should include all disciplines and approaches to all levels of interest and problem-solving approaches in continuing education.

Group H

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ALBERT ADAMS, M.A., *Recorder*

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SESSION 1

At the first session the members of the group became acquainted with one another and learned something about the background experience of each of the group members. Dr. Feldman pointed out the wide variety of backgrounds that the members brought to the group but also stressed some of the areas of commonality which exist.

SESSION 2

The discussion was initially focused on the question: "What behavioral changes in individuals can be reasonably expected in time-limited continuing education activities? How can these be assessed or evaluated?"

Measuring Attitude Changes

Mr. Young opened the discussion by asking how the effects on trainee attitudes can be determined a year or so after a program has been completed. Dr. Feldman responded by describing the pre- and post-conference attitude measurement that the Western Interstate Commission for Higher Education (WICHE) had developed under contract with the University of Colorado. Dr. Feldman also mentioned Lucy Zabarenko's more elaborate system of nonparticipant observation teams which measured before and after behavioral changes in a doctor's office.

Dr. Rosenow brought to the group's attention the fact that we must not rely too heavily upon paper and pencil tests which purport to measure attitude change. He cited some of his experiences as a member of the board of examiners with the American College of Physicians. The gist of his illustrations indicated that even very elaborate methods of observation and measurement do not measure how an individual really feels "deep inside." Dr. Rosenow summarized his feeling about evaluation by the following remark: "There are some things that can be tested which do not count and there are some things that count that cannot be tested."

Dr. Boehm questioned how much evaluation was merely a justification for funds. Dr. Feldman agreed that for most grants some kind of evaluation

is required and has to be built into the program; but he asked for opinions about the requirements necessary for a sound evaluation. Miss Conrath commented on several concepts of evaluation: e.g., the measurement of performance, the measurement of the achievement of objectives, and the measurement of efficiency in terms of input-to-output costs.

The discussion that followed culminated in the general feeling that *evaluation is a process* and not a specific thing or theory. Change is an ongoing process and, therefore, evaluation must also be an ongoing process. Dr. Hume elaborated on this thinking when she mentioned that the purpose of evaluation is to provide information which will allow for more effective interaction. "More effective interaction which overcomes roadblocks to learning is what is desired in evaluations." Illustrating this point by referring to Eric Hoffer's book *The Ordeal of Change*, Dr. Hume said that asking people to change is asking them to go through an ordeal. Indicating some agreement with the points mentioned earlier by Dr. Rosenow, Dr. Hume felt that only in the daily process of interaction can the most effective evaluation be made. It is there that the roadblock can be seen and overcome. Dr. Boehm questioned if the ordeal of change which might apply to many groups was a real problem for professional groups since they are self-motivated and want to continue to grow and continue their education.

Relation of Motivation to Evaluation

The subject of the relation of motivation-to-evaluation was then raised. Dr. Boyd, Dr. Boehm, and Dr. Rosenow were the major discussants. The specific issue was: How do you make evaluations without discussing motivation? Generally, evaluations are used as parts of the reward-punishment system, thus the motivation becomes primarily extensive. The unanswered question was: How can evaluations be used to promote intensive motivation? Throughout these illustrations three basic themes stood out.

1. Evaluation is more than a test of retention. It is also a test of affective change. Affective changes are perhaps the most important changes in continuing activities in the field of mental health.

2. Meaningful evaluation can only be made if one is evaluating some specific objective of the program. Each program has its own set of objectives; even within a single objective there are varying levels of change which can be evaluated. Therefore, no specific set of answers can be arrived at concerning evaluation. Each program must determine for itself what objective is to be evaluated and at what level change is to be measured.

3. The motivation-fear interaction must not be overlooked in making evaluations. Both intensive motivation and the fear of change or of a possible loss of status must be dealt with in such a way as to promote self-improvement and continuing education rather than withdrawal or the masking of true feelings by the trainees.

The group's overall reactions were best summarized by Dr. Rosenow

when he mentioned an ideal for doctors which is equally applicable to all the mental health groups: "We want to set the doctor up with a method of evaluation to assess his own progress."

SESSION 3

Generating Community Support for Community Mental Health Programs

The question raised was: How can realistic goals and priorities be established by institutions and agencies for continuing education programs?

Mr. Young, interested in the development of community mental health centers, not just outpatient clinics, in his State, asked for ideas about program development in continuing education. He wondered how to go about getting professional support for this idea and how then to acquire financial aid from the local businessmen and adequate use of facilities by the townspeople.

Dr. Hume asserted that the worst people to induce to assume leadership in this matter are the mental health professionals. They work best in the background as consultants. It would be better for the professionals to teach mental health concepts to the businessmen and then have the local businessmen take these ideas to the community. The other mental health professionals in the room agreed that it was the local businessmen and other community leaders who should be the ones to "sell" the idea of mental health to the community and not the mental health professionals. Some of the points made in support of this idea were:

- The local businessmen speak the language of the community.
- Finding a procedure helps to involve the community with mental health problems rather than give the professional the responsibility.
- Professionals as the leaders try to indoctrinate rather than consult. This must be avoided because the townspeople will not accept it.

Mr. Young asked how financial support could be obtained from the community. Dr. Hume suggested that a problem area in the community rather than a population group be the focus of concern. Start with a problem and bring the different groups of people in the community to the problem so that the goal is to work on the problem. Dr. Conant agreed, adding that this would solve the problem of financing. Organizations would be more apt to back the people who are working on a problem such as mental health. If you admit that your funds are limited and pick out a community mental health problem whose resolution would benefit the community, the project will gain support.

Mr. Young was still concerned about the problem of getting the professionals and the townspeople to work together on a problem. Dr. Macht recommended the utilization of the natural leaders in the community regardless of what group they belong to. Dr. Boyd suggested that one should seek out the young professionals in the community. Dr. Rosenow suggested

that those people who are aware of a problem be identified first and their help procured. One must work with them and not try to implement the whole program at once.

Miss Conrath suggested that the difference between planning and operation should not be overstressed. Planning a program is a partnership and a dialogue between the professional and the layman. In the operational stage, it is only after plans have been laid that the professional plays a different role than that of the layman. Dr. Tyler said that perhaps part of this process of priorities between planning and operations exists because the public is not taught to think of problems in terms of mental health, even within the mental health field. Dr. Tyler recommended a three-step procedure for generating community support:

1. Identify the problems of the community.
2. Make it clear that we in mental health have something to offer.
3. Then they will come and seek help.

In identifying the problems, Dr. Hume recommended that rather than telling the people in a community what their problems are, one must listen to *them*. Let them tell you and then clarify their concerns. Dr. Boyd said that in such a cooperative process the names of who did what will be forgotten but the commitment to mental health will remain. The affective experience is more important than the intellectual experience. In this way, people become eager to act.

Dr. Feldman recommended that in the early stages of developing continuing education for community health it is better to avoid the technique of one limited contact or short lecture and to concentrate on long-term contacts which create effective changes. Mr. Young thanked the group for helping him with this problem.

Dr. Rosenow referred to unfinished points about the problem of how to develop appropriate integration and appropriate separateness of continuing education activities which involve different disciplines and different levels of experience.

Achieving Effective Communication

Dr. Feldman said that one of the major problems was to obtain effective communication. Excessive concern with content often overlooks the real problem in communication. Communication difficulties between doctors and nurses is a good case in point. Dr. Boyd felt that part of the difficulty in communication was due to the difficulty of interdisciplinary communication. He demonstrated this by the communication problems physicians experience in talking with surgeons. Dr. Feldman thought that it was important for people to begin to talk together when they work on a problem. Dr. Boyd mentioned that in community health work, as well as in general, the worst thing to do in attempting to overcome resistance is to defend yourself and to support your position with statistics. "Keep your mouth shut and wait until

they are in a jam. Then go and help them out. This is what will change their attitude. Do not bowl them over with an intellectual approach." Dr. Feldman reinforced these remarks by saying that example is paramount. Help given where needed, speaks for itself.

Communication Procedures at the Conference

Dr. Rosenow turned the group's attention to the problem of communication within the present conference. He asked what the group thought of the present techniques. His own comment was that the plenary sessions were not extremely valuable to him. What did the group think of this method: of listening to talks; engaging in discussion; listening to recordings? Was it educational, did it help to solve problems, or did it accomplish both? Dr. Feldman felt that it did accomplish both things.

Most of the members expressed some dissatisfaction with the process of reporting back which the conference employed. They felt that the reporting-back process was most useful when each group was working on a single question and the group was highly task-oriented to that question. It was felt that the present conference was on a more general and exploratory basis and therefore reflection on development rather than reporting back was needed.

Mr. Young stated that continuing education begins before the conference by first finding out from the conferees what their problems are. Dr. Hume suggested that one should ascertain whether the audience was uncomfortable about the method used. Was it too limited?

SESSION 4

Training

Dr. Conant asked how mental health professionals can be trained to act as consultants in the public schools. Dr. Hume recommended that in speaking of mental health professionals we think not only of medical doctors but also of psychologists, social workers, and psychiatric nurses. In the ensuing discussion between Drs. Conant and Hume, the following points were clarified:

- It is not always wise to use the professional as the model for mental health training; they are often too specialized.
- There are different levels within which continuing education for mental health personnel can be considered. Different groups of professionals will function better at certain levels than at others.
- Before selecting a professional group from whom you wish to seek help, it is important to pinpoint the objectives of the training program and then to choose professionals who can best help in fulfilling those objectives.

Dr. Feldman said that the major purpose in training people is to enable them to act. If there are no jobs, training is pointless.

Career or Job?

Dr. Macht mentioned that one of the difficulties today is that at the lower occupational levels in mental health, as in other fields, there is no career potential; there are only jobs. Many of the jobs are just above the poverty level in terms of rewards, he said. Vertical or horizontal career lines need to be developed for these people.

Dr. Conant cited examples of how competent persons in a number of different mental health areas were lost from the field because of a lack of opportunity to advance. A lengthy discussion followed with each member of the group offering ideas about how the relationship of training to needs could be made more functional. While it was recognized that the main ideas of the discussion related to basic training programs some were also considered relevant to continuing education.

- Field experiences must be built into training programs to buttress the theoretical work.
- At the lower manpower levels training programs must be designed to fit field needs so that placement is a definite certainty.
- What happens when you create hope and train people and then they do not get jobs? They join the riots!
- The training agencies must be involved in both field experience and placement of trainees.
- The field experience should mark the beginning of placement.
- The people in the various fields of mental health should make their expected manpower needs better known to the guidance counselors of the public schools and not just to the deans and directors of their training schools.
- In view of resistance of professional groups to allow any of the paraprofessional groups to develop, it must be kept in mind that all groups have a need for status and respect.

Accreditation

The group felt that more flexibility is needed than currently exists in the accreditation of work in continuing education. Dr. Feldman said there is little or no opportunity for refresher courses for nurses who had temporarily retired from the field to raise children. Dr. Rosenow thinks that new educational tools will allow for more training on an individualized rather than on a scheduled basis. He mentioned the forthcoming TV tapes which could be mailed to people to play on their home TV sets whenever they had spare time.

Refocusing more specifically upon accreditation, the group felt that

there really was no need for postdoctoral and postinternship accreditation. If evaluation is needed to keep some of the postdoctoral training programs moving forward with the times, perhaps individuals with similar and successful programs could be identified and could make site visits and evaluation reports for one another.

Mr. Young mentioned that individuals below the postdoctoral level eagerly seek participation in a continuing education experience. However, he has learned that some colleges are reluctant to give even certificates of completion of training experiences.

Discussion

Following a summary of the discussion by the recorder, Dr. Hume expressed the need for some kind of continuity and coordination of training experiences for the trainees at the different training levels. She felt that the coordination between the levels would become increasingly important as the focus of mental health becomes one of public health rather than individual patient care. The gap between the psychiatrist and public health specialist is still to be resolved.

Miss Conrath suggested that the basic problem is one of continuity. There is a need to develop an educational counseling service for practitioners. She added that we must develop some systematic learning experiences to strengthen weak spots.

Dr. Boehm said that the goal should be to have a practitioner in good standing, not just a practitioner. Dr. Hume agreed and commented that the purpose of continuing education is to insure continuous learning, not a continuing program.

Dr. Conant indicated that the public schools are a prime agency for preventive training in mental health. Making teachers aware of the problems of mental health among their children is important, she thinks. Dr. Hume agreed but cautioned that even if there is excellent information in a teacher training program, many teachers cannot transfer that information to the actual classroom. Thus, continuous on-the-job training is needed which translates classroom theory into classroom practice. Dr. Hume also felt that summer work-study programs are important to back up what teachers had learned in college. She added that purely academic work is poor preparation unless it is accompanied by supervised experience in field work.

Dr. Conant felt that teaching could move in those directions if State departments of education and other accreditation groups would give more credit for inservice training than for additional course work.

Miss Conrath maintained that the mental health agencies do not give enough recognition to the benefits of field trip experiences. She also stated that perhaps one of our greatest losses is that of not learning to develop a positive attitude toward looking for help and guidance.

Dr. Hume in summarizing much of the afternoon's discussion, asserted that professional identity does not come from being in academia, but rather from being in the field. It was important to plan and make suggestions for fruitful field experiences and field placement.

In closing the discussion, Dr. Feldman asked the group, in preparation for the final day of the conference, to consider any recommendations they might like to make to people at the national and State levels of mental health, and any suggestions they might like to make concerning priorities or needs.

SESSION 5

Coordination and Cooperation

Dr. Feldman opened the session with one word, "Well?" Dr. Hume immediately responded by asking how many of the group had heard entirely contradictory statements in the morning session? Was coordination accomplished at the national or the local level? Dr. Feldman thought it was achieved at both levels. Miss Conrath asked for a definition of coordination.

Coordination involves day-to-day relationships, the coordination achieved by professionals rather than that handed down from on high, was the opinion of Dr. Hume. To pinpoint the definition, Miss Conrath asked if this implied a process. Dr. Hume said it did, a daily process and went on to explain that she felt that different levels involve different levels of policy and that at the local level coordination can be very time consuming. She stressed that policymakers should not toy with coordination by fiat and pretend there has been coordination at the local level unless there has been some.

Miss Conrath felt that different groups could be brought together through continuing education. She thought that without trying to create resources in every institution, continuing education could help communicate the experiences and findings of different institutions. Also, Miss Conrath said that trying to plan and develop projects as part of an overall regional medical plan is a new idea and requires a great deal of careful planning.

Dr. Feldman pointed out the growing number of regional organizations and wondered how they can be successfully coordinated. Dr. Hume stated that there is more money than manpower and with the duplication of organizations the limited supply of manpower is being wasted. Dr. Feldman pointed out, "Our greatest concern is that each of these organizations is going along without knowing what the others are doing."

There was agreement that there is need for coordination among all of the regional programs. Miss Conrath pointed out that it is difficult to get these new groups to cooperate because each group is trying to establish its own beachhead. Dr. Hume agreed, likening the difficulty to a fight to survive.

Recommendations to NIMH

Dr. Feldman now focused the attention of the group upon recommendations to the national level, that is, NIMH.

Dr. Boehm felt that the national level might serve as a receptacle for ideas which would subsequently be disseminated. Dr. Feldman and Dr. Boehm reacted to the current practice of making available 100-word summaries of approved grants as too limited to be of value. They also desired more information about applications that are not supported.

Dr. Tyler wondered if that would not raise a lot of problems concerning ethics and confidentiality. The group agreed that it was a difficult problem but felt that it was one that could and should be overcome. It was pointed out that the problem is not only one of where information or ideas can be found, but of how systematically they can be retrieved and acquired in digestible form. The group stressed that there is interest in pilot projects, community demonstrations, and relevant biological-scientific information, not solely research grants. It was felt that there is a need to demonstrate how to improve the application of research findings already available.

The basic consensus of the group was stated by Dr. Feldman when he said, "We do not know about the non-NIMH programs, of which there are hundreds. We each have our own bit of the picture but nobody really seems to know the whole picture."

Dr. Hume made the recommendation that the continuing education branch should provide increased consultation and, if necessary, funds to set up, as a separate project, the dissemination of information on continuing education in mental health.

Miss Conrath indicated that much of the collection of work could be handled by MEDLAR* but that support of additional staff would be necessary to make dissemination effective.

Postscript

At the end of the session, Dr. Hume requested that the following be inserted into the record:

"In the report of another group, *identity* was mentioned as a target for groups in mental health. With the development of a new group of mental health continuing education workers, in addition to the professional and nonprofessional groups, it was recommended that there be a coalescence of identity of these groups. This is a very dangerous idea. We should work on the problems but not try to solve the differences by creating a homogenization of the training and identity of mental health professionals."

* Medical Literature Analysis System

Group I

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IVAN M. LAPPIN, *Recorder*
C. L. WINDER, Ph. D., *Collator*

SESSION 1

Individual and Small Group Problems

Chairman Wilkinson began the session by having each participant introduce himself, his affiliation, and his particular interests relevant to attendance at this conference. After the self-introductions, questions about particular affiliations and interests were welcomed.

Chairman Wilkinson briefly introduced the progressive process of the five discussion sessions, beginning with a focus on individual and small group problems in mental health continuing education and continued through the consideration of national programs. He then pointed out that specific questions had been listed to stimulate the group discussion. After reviewing the questions, the participants arrived at a consensus that questions 5 and 9* would be foci of the group. Further continuing education needs should be differentiated, i.e., for professionals, new professionals, nonprofessionals, and volunteers; and that continuing education should not be regarded as just taking classes, but as a process taking on different modalities according to the different learner groups and purposes of the program.

Motivation to Participate

In the discussion there was agreement that an individual may be motivated to relieve his anxiety in confronting a challenging situation by learning more about the situation. His actual participation is the end result of a series of conflicting motivations, and he participates according to the hierarchy of his total commitments. His actual participation in continuing education may satisfy more than the motive to decrease his anxiety, such as the wish for extrinsic rewards of society in the form of status and/or financial gain. If society regards continuing education only as good, but does not demand it, then societal expectations will likely not be strong motivating factors. Individuals may resist continuing education because it puts them in an uncomfortable role by placing their current practices into question. For example, Mrs. Hendryson mentioned PTA educational programs regarding

*See appendix B.

childrens' acquisition of smoking and drinking habits. If parents already have these habits they tend to resist such educational programs because their own behavior is called into question. However, if the emphasis is put on the child's and not the parent's habits, the parents are relieved and become more willing to participate in an educational program.

A person's investment in continuing education may be either positive or negative. It is negative if he chooses to participate only in those activities that will reinforce his current thinking and practices. To participate in a positive manner, the individual enters into the learning situation with the intent to change his practices. Even to participate in such a manner, he must weigh his time investment against possible participation in other types of continuing education, and in other types of professional or personal activities. If the individual invests his time in the development of a continuing educational program he is more likely to participate fully in it. For example, Dr. Weiner described a program for general practitioners where small groups of 4 to 5 were brought in for discussions during which they could present their felt needs for mental health education to the program planners. Approximately 80 out of a total of 110 general practitioners to be involved in the program were thus contacted, and the ensuing program was developed on the basis of the commonality of need expressed. The planners insisted only on the restriction that the case study approach be used in the program and that no lectures be allowed. Involvement in the planning in this manner seemed to alleviate any concerns the planners had about recruitment and financial problems. The participants were also involved in the development of their own curriculum materials. The involvement practices seemed to motivate the learners and provide an investment of time as well as a reinforcement of their motivation through a continual feedback of what had been learned. The involvement of the learners brought together the often dichotomous positions of the experts and the learners into a team approach to the solution of problems. In summary, the participation of professionals in the development of their own continuing education programs seems to hinge strongly on their investment in the planning and development of the particular activities. If the learners are involved, then their felt needs are identified, their anxieties about participation are brought out and dealt with, they understand and are less concerned about the role of the learner, and they have the opportunity to work on problems that are of immediate concern to them.

SESSION 2

Learner Involvement

This session began with a further discussion of learner involvement in the development of continuing education programs. The discussion included the general consensus that continuing education programs in mental health

have got few learners involved in this manner, but the approach would be consistent with the philosophy expressed by Chancellor McNeil in his presentation. Involvement of learners seems to be a way of approaching general practitioners who, as a group, are particularly hard to interest in continuing education on mental health problems. Dr. Weiner expanded his description of his efforts with the general practitioners in Dorchester, Mass., by indicating that the practical questions of the learners kept the teaching team on their toes at all times. In fact, if a session went too smoothly, the planners had a good indication that little learning was taking place. They insisted that the teachers could not use professional jargon, but had to talk in language general practitioners would understand. In addition, the 18 month program was followed up with a consultation service so that when in practice a participant confronted a problem he didn't know how to handle, he had the resource of an expert available around the clock.

The group generally agreed that a boon to continuing education would be the preparation of "continual learners" in basic education and in medical and professional schools. Such efforts in medical schools seem to be evidenced only in new and developing schools that are experimenting with innovative curricula. In addition, the professional school needs to provide constant support to its graduates' continuing education endeavors. Dr. Sheats gave the example of Oakland University in Michigan which has developed an alumni continuing education program in which each graduate is assigned to a counselor who maintains contact with the alumnus as he enters his career.

Rewards

The rewards supportive of continuing education were again discussed. Some expressed the thought that academic credits could be given for continuing education programs, so that individuals could advance toward some type of certification or other standard, and that ideally, participation in continuing education would somehow be synonymous with success in a particular profession. Dr. Weiner said that the general practitioners in his program, once involved in the planning and development of the activity, were not using the academic credit that was available through participation. He also indicated that if the participants are too pleased with the program initially, the effects of the activity can be either nil or negative. First of all, general practitioners or even the migrant worker with whom he works, must be confronted with the fact that they need to know, and that they are being ineffective in their work and life. If immediately satisfied and rewarded, the participant tends to be confirmed in his present state of knowledge and understanding.

Role Definition

The major portion of the session was devoted to the discussion of role definition, execution, and conflict. Several examples were given of how

the product of continuing education, in other words the changed or potentially changed practices of the learners were not welcome within the agencies, institutions, or even the society in which the learners wished to function. In a sense, general practitioners as self-employed professionals have more freedom to change their practices, but nurses and others working within bureaucratic structures have little control over their role execution. Often, nurses make exceedingly effective clinicians in psychotherapeutic situations, but because they have no identity or legal basis for doing this work their skill cannot be recognized nor can they be promoted. Because of some fairly narrow legal restrictions on practices by the various mental health professionals, such people as nurses are hesitant to perform often beneficial but risky roles. The source to change the narrow definitions seems to lie in the professional associations which usually set the policies that later become law. Usually, however, before such definitions are set by associations someone has to stretch the boundaries of existing practice to set new patterns that later become acceptable. In respect to changing and broadening role definitions, the mental health professions seem to be ahead of the rest of medicine, but further communication is necessary to realize that the approach to mental health practice is interdisciplinary and that needs exists for everyone in the field. Even as roles are expanded the problem of relative status by different professionals both within and without the mental health professions is a compounding problem which restricts the freedom of execution of changing roles.

In conclusion, the point of view was expressed that continuing education programs could best be developed in institutions by administrative acts. This point of view was immediately countered by the view that professionals themselves had to actively initiate continuing education programs if they are to come about and be accepted by the administration. A mediating point of view was offered that both levels of interest were important. The issue was not resolved and was left open for further discussion.

SESSION 3

Developing Continuing Learners

The session opened with a further discussion of ideas about developing continuing learners in basic education and professional schools. The group agreed that initial educational experiences should be inquiry orientated, but also agreed that by the time individuals got into graduate schools the degree itself became such an important goal that education took on a terminal character. They also thought that a considerable period of time elapses before the graduate begins to realize and articulate his inadequacies and hence becomes motivated to participate in continuing education. It was also felt that open, inquiry-oriented types of continuing education pro-

grams could encourage professional schools to emphasize the development of continuing learners.

The development of agency-continuing education programs was the topic of considerable discussion. The general feeling of the group was that continuing education programs for professionals and volunteers should be the responsibility of the specific agencies in which they work. Agency responsibility does not mean, however, that each agency conducts its own programs, but should take advantage of and encourage participation on the part of its professionals and volunteers in continuing education opportunities offered by other agencies, institutions of higher education, and branches of government. This interinstitutional approach does mean that a central coordination function would be needed to avoid excessive duplication of effort and to serve as a clearinghouse for information about the mental health continuing education opportunities available to all professionals and volunteers in a community. The coordination function could be provided by the community health centers, or by an institution of higher education, or by both. Dr. Sheats indicated that the plan for higher education in California could serve as a guide to the distribution of responsibility among those public institutions involved in the coordination. However, for private agencies who are also involved, a communitywide planning effort is needed so the resources of all agencies are most appropriately used. At this point the role of the university in community mental health programs was questioned. Mr. Nitzberg expressed the opinion that NIMH was more likely to fund community health centers that had university affiliation. The general feeling of the group seemed to be that universities function from an impartial and nonpolitical basis to involve all of their resources, as well as the resources of other agencies and institutions, and those of private industries, but that they would not take over the total program in any case. Whichever agency or institution serves the coordinating function, each specific agency must be involved in the development of continuing education programs, so that each has a positive attitude toward the participation of their own professionals and volunteers in continuing education. Also, the agency or institution having the most expertise would thus be ready and willing to provide the program of continuing education in that subject.

Role of Voluntary Agency

The question was raised as to the role of the voluntary agency in the face of the continuing expansion of responsibilities of mental health agencies and community health centers supported by public funds. After a considerable amount of discussion and analysis, the group seemed to feel that voluntary agencies have often become rather rigid and self-perpetuating in their services, while ignoring other needs in a community, whereas agencies with a broader responsibility and more consistent financing can handle a wider

range of problems. However, the voluntary agency is still needed to carry out the important function of seeking out new areas of need, and innovatively developing the pioneer efforts that government and other bureaucratic agencies can eventually take over but find themselves too restricted in policy to initiate. This means that voluntary agencies cannot allow themselves to become rigid in their programing.

With the increase in bureaucratic programing, the individual volunteer may lose his sense of community obligation. But volunteers are needed as board members of both voluntary and of the governmental health agencies to help professional workers to understand the problems of the community. Such understanding can best be effected if board members are not dominated by the agency administrators. The continuing education of volunteer board members, then, needs first to be focused on seeking out and analysing community problems, so that the agency can remain flexible in its approach to problem solutions. If board members are trained only on how to set policy in a specific program, then when that program becomes obsolete, so does the board.

SESSION 4

Development of State Programs

Session 4 began with a brief discussion of the development of statewide mental health continuing education programs. Mr. Nitzberg felt that such programs could best be developed through professional associations because the participation of the learner in program development could be more assured in this manner. However, professional associations often have limited resources for continuing education, and such an approach might best serve for certain task force or problem-oriented education programs, but would be insufficient for an ongoing program. Mrs. Hendryson expressed an appreciation of statewide programs in public mental health education and indicated that the national PTA was trying to stimulate such programs with the American Psychiatric Association, the American Psychological Association, and the Pediatricians' Association. They have found that national efforts such as this are not successful, but efforts on a statewide basis seem to be effective. Even though such programs may create a demand for services not yet available, such demand may result in services being provided. The PTA has also been involved in recruiting efforts to interest the young adolescent in a career in the health professions, especially nursing.

Short- vs. Long-term Educational Experiences

The group then became involved in its most lengthy and spirited interchange of the conference. This discussion seemed to center around the length and continuance of an educational program. Whereas most of the members of the group were quite pleased with examples of 1- or 2-day

programs for mental health professionals as well as for policemen, clergymen, and general practitioners, Dr. Weiner expressed real reservations as to the value of such short-term educational experiences. While short-term activities can take advantage of topnotch experts while they are in a locality and seem to be used more and more by university extension programs, Dr. Weiner's experience was that such short-term contacts with the learners can give only a little knowledge without understanding. However, extensive continuous contact with a group can result in a group dependency and not give the learner enough confidence in his own independent actions.

As a result of considerable discussion, the group began to reach some resolution about the length of an educational program. They felt that with professional people learning in a content area related to what they were doing and within the context of their working group, 1- or 2-day programs could provide some stimulation and content that could be incorporated into their ongoing activities. However, with certain content to be presented to people outside of a particular profession, such as teaching case referral procedures to general practitioners, short-term activities have dubious and perhaps even negative effects. Many may go out and try to act as experts on the content without real understanding, and others may be initially scared away from further interest or learning in the content area. Thus, for non-mental health professionals, continuing education programs, other than those designed only to create interest, need to be of a continuing nature, and consultation services need to be made available to learners as they attempt to apply what they have learned in their own practice. The short-term efforts now being provided may constitute only an initial dabbling which teachers may be reluctant to drop because it is at least some activity. But the result may be that people become unhappy with their current practice but are offered no way to learn to change. Each continuing education effort must thus be well planned and executed and the learners should be followed back to the job to see if his practices have changed.

SESSION 5

Questions Raised

The initial focus of session 5 was an "air clearing" discussion about the effect of Dr. Weiner's criticisms about short-term educational programs on the thinking of the rest of the participants in the group. In general, the types of considerations brought out in the report of the previous session were confirmed. The overall effect of Dr. Weiner's criticism was that he had raised serious questions in everyone's mind about the effectiveness of their own continuing education programs and they would need to heed the caution that not just any activity is good. His criticism, while raising serious questions, will not deter them from trying different types of educational programs. His criticism seemed especially applicable to mental health continuing education with

general practitioners because this group seems to be hard to reach. As a concluding note, the group seemed to agree that Dr. Weiner's criticism of short-term programs was seriously countered by his very effect on the members of this group during the short 2 days that they had participated together.

Recommendations

The discussion continued with a call for the National Institute of Mental Health to provide more guides and criteria for the evaluation of programs in mental health continuing education. It was also suggested that NIMH encourage and perhaps even require evaluation of continuing education programs of various time spans. In the light of the uncertainty in the group about the relative effectiveness of length of educational programs, the question of sources of information about evaluation in continuing education was raised. One useful source was mentioned, a book by Harry L. Miller entitled *Teaching and Learning in Adult Education*, published by the Macmillan Co. of New York City in 1964. In addition, the request was made that NIMH act as a clearinghouse for information on continuing education in mental health, or perhaps even as a clearinghouse of clearinghouses where the sources of such pertinent information were available.

The group seemed to think that national programs in mental health continuing education could best be conducted on a regional basis, and that the staff of the Continuing Education Branch of NIMH should be increased to help the regions develop their programs. They also felt that continuing education specialists should be assigned to each region for the purpose of developing regional programs. The group's criticism of differences in regional boundaries within governmental and other agencies was expressed. Reorganization as suggested was recognized as exceedingly complex and not necessarily the solution to the problem under consideration. It was agreed that under whatever structure, there should be more subregion or problem-oriented continuing education programs. Among those mentioned were mental health continuing education in rural areas or in metropolitan areas; or in relation to problems of certain target groups such as the aged.

PART THREE

**Digest of
Recommendations to NIMH
Conference Evaluation
and Followup**

**DIGEST OF RECOMMENDATIONS TO NIMH
ARISING FROM
NATIONAL CONFERENCE ON CONTINUING EDUCATION
IN MENTAL HEALTH**

- I. Recommendations* which emerged from discussions in groups and from summaries of collators:
 - A. NIMH should *serve as a clearinghouse* for:
 1. Information about continuing education in mental health.
 - a. Bibliographies.
 - b. Model programs.
 - c. Pilot projects.
 - d. Approved projects.
 - e. Disapproved applications.
 2. Continuing education resources other than the National Institute of Mental Health.
 3. Reports of utilization of research in continuing education.
 - B. NIMH should *provide support* for:
 1. Training of key personnel in continuing education in mental health.
 2. Planning for continuing education program development.
 3. Training key personnel to optimally utilize nonprofessionals.
 4. National and regional conferences.
 - C. NIMH should *provide consultation* in continuing education program development in mental health.
 - D. NIMH should *encourage accreditation* for continuing education.
 - E. NIMH should *encourage general development of the field of continuing education* by fostering:
 1. Cooperation among agencies at the national level responsible for continuing education programs.
 2. Development of consortiums.
 3. Development of continuing education programs which focus on prevention as well as treatment.

*These recommendations were gleaned from the recorded proceeding of the conference; they have not been edited or supplemented for purposes of completeness, balance, priorities, feasibility, etc:

4. Coordination of continuing education programs in mental health at the State and local levels and between universities and agencies.

F. NIMH should *develop guides and criteria* for:

1. Program development.
2. Evaluation methods.

II. In the summary session Mr. McGlothlin made the following six recommendations:

- A. Support leaders in continuing education in mental health in established organizations, such as State departments of mental health.
- B. Support regional educational agencies such as WICHE, SREB, and NEBHE in mental health programs and special projects.
- C. Provide funds to universities with adult education programs for *stipends* for mental health continuing education educators. (To study about continuing education *or* should it be health education?)
- D. Establish an annual conference on continuing education.
- E. Contract with universities to make and publish studies of continuing education in mental health to build a theoretic base for specific activities.
- F. Establish experimental programs intended to discover new methods and solutions of persistent problems in the field. (This would not be research in the sense of review of existing activity, it would be actual experimental programs.)

M.E.H.

CONFERENCE EVALUATION AND FOLLOW-UP

Post-Conference Questionnaires

While it was recognized that there were many variable factors present in the conference and that assessment of the results could not be precise, it was decided to make an attempt to determine whether the objectives of the conference had been attained. The familiar device of post-conference reaction was used to provide an appraisal of participants' response to the conference. Two questionnaires were mailed to each participant.

One of the two questionnaires related to objective data which it was thought would have value both to the conference planners and to the University of Chicago Center for Continuing Education. In addition, these anonymous responses served as a backdrop for those from the second questionnaire in which the focus was on subjective impressions. The questions included in the second form, which was signed, were open ended and

were associated with reactions to all parts of the conference including scheduled sessions, informal discussions and library materials.

Anonymous Evaluation

Of the 90 participants to whom the two questionnaires were sent, 64 responded to the first or anonymous evaluation.

Most of the conference group were very experienced conference participants. Of those responding, 46 or nearly 75 percent had been attending national and regional meetings for more than 10 years, while 37 percent of these had been going to comparable conferences for more than 20 years. The general tone of the comments relating to the realization of expectations, was one of considerable satisfaction with the conference. Several participants spontaneously sent enthusiastic letters following the conference, before receiving the questionnaires. 48 percent replied that the conference was about what they expected. One participant in this category commented that his preference would have been for a slower and more casual approach because "the group didn't need any pep talks." Another comment was that "there was too much structure which was not necessary."

A sizeable group of the respondents to the questionnaire, 40 percent, had rather high expectations which they said had been realized. One of the long experienced conference participants commented, "This conference was one of the best—if not the best—which I have attended." Another said, "Many fringe benefits included becoming acquainted with others working in this field. This was a needed conference with good preconference material and good solid design."

The remainder of the respondents, 12 percent, who came with relatively high specific expectations of their own, said the conference had not fulfilled their hopes. Some of the reasons given were that "the conference never really took issue with the question of whether the professional community would give the sanction necessary to engage the nonprofessionals in training and permit them to undertake roles and functions that many professionals consider their sacred province," that "definite recommendations on coordination of mental health activities had not been made," and that "much of the theory of inservice training and staff development had already been covered in some continuing education programs and we were looking for specific illustrations of ways in which the theory already advanced was being put into practice."

Compared with the reactions of other participants, 18 thought they probably got more out of the conference than many of the others. A much larger number, 34, considered they got about as much as the next person. Ten thought they probably got less out of the conference than most of the others and two made no comment.

The reaction to the conference as a whole can be noted from the table below:

TABLE I.—*Reaction to the conference as a whole.*

	Excellent	Good	Average	Fair	Poor	No comment
Compared to other meetings						
I have attended.....	13	36	7	5	8
Timeliness and significance of conference.....	44	14	3	2	
Objectives clear and realistic...	5	18	20	14	6	
Setting and physical arrangements.....	35	21	5	2	1
Organization and design of conference.....	18	27	11	6	1	1
Selection of participants.....	25	29	6	2	1	1
Plenary Session presentations..	11	24	19	8	1	1
Small group session.....	17	23	14	6	3	1
Background materials.....	16	19	18	7	3	1

Signed Evaluation

There were 50 respondents to the signed questionnaire as compared with the 64 who completed the anonymous form. The signed questionnaire had questions which required more time and reflection for completion.

Because the questions were open ended and concerned many issues, there were almost as many views expressed as there were numbers of respondents. On the whole, results defy categorical listings. For example, it was difficult to see any significant cluster among the varied and sometimes vague responses about content areas. However, more than two-thirds said they learned something new about continuing education: in universities including extension divisions; in large corporations; in mental health programs and institutions as well as in education programs; and about methods and techniques in adult education. One person commented on learning about the changing attitudes of psychiatric personnel toward professional education. Another was impressed with the range of NIMH's interest and stake in continuing education. A few others commented on the new perspective in continuing education as well as on work which has already been done in industry and in various government agencies. One comment reflected the attitude of several respondents about these contributions:

"I was impressed by the effective way Less is approaching the field of continuing education. We were cautioned against repeating earlier ineffective efforts."

Several mentioned the value of the evening sessions relating to visual and

other technical media. Emphasis on ways to overcome communication difficulties was considered valuable by many.

In response to questions about the participant's own contributions which aroused the interest of others, some briefly stated "industry and changing times", "executive development experience", and "case material." Other statements of contributions were more detailed as to ideas conveyed, such as "that teachers for training courses should be recruited from the ranks of those working in the field or content areas to be taught"; and that "continuing education was as much an agency as a university responsibility." Nineteen thought some of their attempted contributions were missed or not well received, usually due to factors such as the difficulty in presenting complex concepts during brief informal discussions or the difficulties in modifying strong preexisting attitudes of others.

The responses to the question about attitudinal changes experienced showed the following breakdown:

No change in attitude.....	20
No response.....	8
Some change but not specific as to area of change.....	13
Yes, and definite about area of change.....	9
Most often mentioned area of change:	
The importance and need for a much broader perspective of continuing education	7

A number of those reporting no change in attitude indicated they already had a heavy investment in the area of continuing education. Among the respondents who felt their attitudes were significantly changed were some who had been stimulated to think further in regard to teaching and evaluation methods and to reach a broader audience, such as advisory or administrative boards.

One experienced participant from the health field commented at length as follows:

"(1) I was impressed with the recognition given by the mental health people to the field of adult education. The papers carried a heavier than usual component of learning theory, of perceptions, motivation and evaluation. This is a significant movement in light of the 'Big Four' in the mental health field: psychiatry, psychiatric social work, psychiatric nursing, and clinical psychology. Up until now, the mental health community has largely been a 'closed society' with very little willingness for entry from the fields of adult education and even from parts of the group work field and community organization.

"(2) One of the interesting distinctions between the 'mental healthers' and the rest of us in the health field is a different way of discussing problems in the field of continuing education, i.e., behavior change is discussed in psychiatric terms by many of the mental health people whereas others in medicine, when they talk about the goal of education as behavior change, think of it in terms of relearning and cognition. The mental health

people tend to discuss behavior change in the total personality sense focusing on the elements of personality structure and image.

"(3) Another distinction is the emphasis of citizens as part of the target audience for continuing education programs. The interest to me is much keener in the mental health field for citizen learning than in other fields of health. There are probably several reasons for this emphasis including the recognition that the solution of many of the problems will indeed come from the citizen community rather than the professional community. Another distinction, it seemed to me, was acknowledgement that the substance of continuing education programs, the subject matter itself, really is lacking for some of the most pressing fields today in the mental health area, namely juvenile delinquency, drug addiction, increasing crime rates, etc.

"(4) Recognition that the ways in which community organization has been taught and is currently being taught, for example, are really not applicable to today's power structures and societal problems. This is particularly evident in discussions addressed to problems of low-income groups and the ghetto area. Learning how 'pockets' of the community approach decisionmaking means learning from many 'subordinate' nonprofessionals. So in a sense the 'faculty' for continuing education may be labor leaders, civil rights authorities and many others outside the medical milieu. Attitudes of professional mental health people to listen to such sources of information and act upon it requires a new way of thinking.

"(5) Another distinction it seems to me, is the different perception of a multidiscipline approach from the way in which other fields in health may consider multidiscipline approach. In the mental health area, the roles of the social worker, nurse, etc. are well established and there really is no interchange as much as coexistence."

There were 35 positive as compared with 15 negative responses to the question about reinforcement of prior positive attitudes about continuing education. A cluster of 13 statements supported the "need for continuing education in the professions." Some saw evidence of greater need for better planning and coordination in continuing education programs in mental health. A fairly large number mentioned the need for closer integration of continuing education for all professional disciplines, business, labor, and government in the interest of stronger mental health services. Several strongly voiced conviction that the potential students own recognized needs must be taken into account in terms of timing and content in continuing education. The importance of the interdisciplinary approach was stressed by a few as was the conviction that university programs cannot or will not rise to the needs of operating mental health agencies. A statement, "traditional roles in mental health care are outmoded and new patterns of utilization will emerge", supported another similarly expressed conviction. Others thought there was need to continue educating our professionals in the new modalities of the field because "so many seem to continue to practice in a rigid mold".

The diversity and small numbers of responses to questions about surprising or unexpectedly impressive conference experiences, or to disappointments or negative experiences, were either quite individualized or not specific enough for purposes of evaluating trends. Some of the responses were similar to points mentioned in previously quoted remarks.

Responses to the question regarding specific areas of their work which would be influenced by the conference included:

"* * * will increase stimuli to provide more courses * * * flexibility in planning * * *."

"* * * better understanding of professionals."

"Hope to communicate to a much greater extent with State mental health professionals in the coming year."

"A deeper sense of understanding and appreciation for the mental health field * * * interest in and concern about * * * continuing education."

"Will be more aggressive in suggesting training and utilization of other human resources in implementing and expanding services."

"My planning activities will be very much affected."

One respondent stated a very specific consequence of the conference, i.e., his agency would apply for grant support of a continuing education program. Others included: better ability to consult in continuing education problems; acceleration of agency staff development program; work out better use of advisory committee; maximize the interdisciplinary approach in presenting course content; encourage close cooperation between agencies and educational institutions; encourage leadership of junior staff interested in extending their training efforts in new areas.

Suggestions for the future clustered around the need for followup conferences at a regional level. Individual responses included:

"It might be worthwhile to consider preparing an annotated bibliography of a few of the best articles and books about aspects of adult education."

"I would have preferred more formal papers, with small groups having specific and limited charges."

"Consideration of how to get 'action programs' in the field of continuing education underway on a broad scale, i.e., managing continuing educational programs in mental health."

"Since all tend to look for specific help, perhaps a conference should be planned on 'how we did it,' and 'why we did it.' Reports on failures would also help us to avoid improper procedure."

Responses to the question about issues which deserve research included:

"* * * too many issues to single out one."

"Evaluation of effectiveness. Styles of teaching."

"The development of definitions of functional roles that are appropriate to the design of curriculum for training that is relevant to functions that are to be performed."

"Feasibility studies as to how to reach those who might need continuing education."

"Evaluation of continuing education programs."

"Interdisciplinary educational experience where appropriate. One would hope that more effective 'working together' might flow from satisfactory 'learning together' experience."

Followup

Since the conference, the editors of the proceedings have become aware of many events and influences that stemmed rather directly from the conference. Informal contacts with participants have revealed a wide variety of productive acquaintances, new types of collaboration, altered thinking, and continuing education program developments that have arisen from the conference. The partial and indirect influences have been more extensive but more difficult to assess. While there has been no attempt at formal or complete followup, the types of changes are indicated in the introduction and in the paragraphs below. Naturally, the editors are most aware of the conference impact on their own activities at NIMH.

A number of recommendations to NIMH made by conference participants through the small groups are listed in the preceding section of part three. While not all recommendations are consistent with the assigned mission of NIMH, a number of activities sponsored by the Continuing Education Branch since the conference reflect interest and efforts to implement some of the suggestions made at that time. A project which has been completed is the publication in 1969 of a series of seven annotated bibliographies. Entitled "Health and Mental Health Training Methodology Bibliographies," they are available through the Government Printing Office. They were developed as a joint effort of the National Institute of Mental Health and the National Communicable Disease Center of the Health Services and Mental Health Administration, Public Health Service, U.S. Department of Health, Education, and Welfare. The project was administered collaboratively by the National Institute of Mental Health's Community Mental Health Centers Staffing Branch of the Division of Mental Health Service Programs, the Continuing Education Branch of the Division of Manpower and Training Programs, and the Training Methods Development Section of the National Communicable Disease Center.

A strong recommendation to support the training of key personnel in continuing education has become a high priority in the Continuing Education Branch program. One action was a workshop to enhance the development of existing leaders in mental health continuing education which was held in Atlanta, Ga., in May 1969. The participants were full-time continuing education program directors in schools of social work and in national, State, and local agencies. Focused on planning for their own continuing education, it was conceived as the first in a series of efforts to be sponsored by the Continuing Education Branch to assist program directors in the development and

implementation of sound comprehensive programs in social work-mental health.

A subsequent workshop, funded by NIMH, which promises to have nationwide impact was sponsored by the Council on Social Work Education. It was held in Syracuse, N.Y., in April 1970, for 30 full-time directors of continuing education programs in schools of social work. It focused on organizational and programing aspects of continuing education, adult learning concepts and practices, and resources within and outside the university necessary for an effective continuing education program. Goal setting was a central theme. Adult educators, staff of NIMH and other government agencies and of voluntary organizations who had attended the Chicago conference were represented in the planning group, and some participated in the workshop.

Less direct, but influenced by and traceable in part to the conference, has been the noticeably increased tempo of continuing education activities for directors of continuing education programs, instructors and administrators of mental health agencies involved in continuing education programs at the national and regional level. Some national professional organizations which were represented at the conference have for some time supported continuing education activities for their members and allied professionals. Some changes and increases in their activities have been influenced by the conference.

For example, the American Psychiatric Association has for many years fostered psychiatric postgraduate education for physicians. Since the conference, more active use has been made of educational consultants other than physicians, including acquaintances established at the conference. More intensive and innovative efforts for training directors of continuing education programs are evolving. Another example was the involvement by a conference participant from the National Communicable Disease Center in a later meeting of the Association of Southern Professors of Psychiatry. The professors became acquainted with the resources in training methodology at the Public Health Service Communicable Disease Center and had a demonstration session similar to one of the evening elective sessions at the conference.

In order to implement efforts to develop continuing education experts, a task force composed of a small group of Continuing Education Training Review Committee members and NIMH staff was appointed in January 1970. It was charged with the examination of ways to insure the increase of continuing education leaders and program directors in the field of mental health.

The recommendation that NIMH should provide consultation in continuing education program development in mental health, including curriculum design and implementation, was viewed by the staff as having good potential. Initially focused on providing consultation to prospective grant applicants who are encouraged to submit proposals for review and informal staff

reaction before submitting an official application, the function has been extended. Requests for consultation on a broader basis have been initiated as a result of papers, a number of which were presented at various meetings on the invitation of conference participants. Demands for consultation have also been stimulated by staff participation in workshops and institutes which have been the result directly or indirectly of continuing contracts with individuals who attended the Chicago meeting. As the NIMH continuing education program has developed and as more definitive criteria for comprehensive program development and evaluation have emerged, the role of staff as consultants will no doubt be even more clearly identified and expanded. It will obviously be limited to some extent by the number of staff positions available to carry out the recommendation to its fullest potential.

The statement above about "more definitive criteria for program development and evaluation" refers to the way in which the recommendations relating to these issues are being carried out by the Continuing Education Branch. A statement, "Objectives, Priorities and Guidelines" developed jointly by staff and the Continuing Education Training Review Committee is available and has been distributed to many persons in the field. A task force made up of experts in research and continuing education, several of whom had been conference participants, met with branch staff in April 1969, to consider and assist in developing a statement on "Evaluation of Continuing Education Programs in Mental Health." As a result, a publication on the subject is now available and copies have been distributed to persons in the field.

Other efforts to implement some of the conference recommendations are in process. The interest of staff and individuals with responsibility for the development of sound programs in continuing education in mental health remains high. Continuing education is seen as a force and as a significant but underdeveloped part of the educational continuum, and it is hoped that demands from the field will have an important impact on future developments.

M.E.H.

PART FOUR

**Supplementary
Materials**

**APPENDIX A
SELECTED PRECONFERENCE MATERIALS**

**APPENDIX B
OPTIONAL SESSIONS
DISCUSSION QUESTIONS**

**APPENDIX C
EVALUATION QUESTIONNAIRES**

**APPENDIX D
ROSTER OF PARTICIPANTS**

Appendix A

Selected Preconference Materials
Distributed to Participants

DEFINITIONS OF CONTINUING EDUCATION

THOMAS G. WEBSTER, M.D.

SOME KEY THEORETICAL ISSUES IN INSERVICE TRAINING, MALCOLM KNOWLES, Ph. D.

INSERVICE TRAINING IN INDUSTRY: THEORY AND PRACTICE, LOUIS R. MOBLEY

NATIONAL CONFERENCE ON CONTINUING EDUCATION IN MENTAL HEALTH

I. DEFINITIONS OF CONTINUING EDUCATION

Compiled by

Thomas G. Webster, M.D.

National Institute of Mental Health

Continuing education has many meanings. Questions of definition arise early in most discussions, especially when a variety of occupational groups are being considered. The present material is written in the hope of avoiding undue conference time being spent on problems of definition. This effort will be facilitated if each participant and each discussion group makes clear the use of terms in the context of specific discussions.

For purposes of this conference, *continuing education will be broadly defined to include inservice training, staff development, postgraduate education and adult education*. The term excludes formal education for a degree, specialty training for certification and full-time basic training of long duration.

For purposes of National Institute of Mental Health programs, continuing education should be mental health relevant with emphasis on meeting the public need for improved mental health manpower and services. However, this should not exclude conference consideration of matters relevant to the broader field of continuing education.

When continuing education is defined in general terms that are universally applicable there are always unanswered questions for specific occupational groups and specific educational programs. When defined with a specific occupational group in mind there are always ambiguities or inappropriateness for some other group. A number of conference participants are fully capable of writing a chapter on problems of definition of continuing education. If a conference discussion group wishes to propose a definition or make a statement on definition for general use of the field, that would be a very welcome contribution.

Following are examples from other groups who have struggled with the problem of definition:

1. *Continuing Education and Training for the Health Professions and Health Related Activities*. A Report to the Surgeon General, Public Health Service, by his Ad Hoc Committee on Continuing Education and Training.
2. *Inventory of Federally Supported Extension and Continuing Education Programs*. Report to the President's National Advisory Council on Extension and Continuing Education. Prepared by Greenleigh Associates, Inc.

Both of these contain operational definitions for purposes of the work of the two task forces represented. *The definitions are not official policy statements of the Federal agencies involved.* They are examples of the fact that to some degree each group or project must arrive at its own operational definition of terms such as "continuing education".

Excerpt from *Continuing Education and Training for Health Professions and Health Related Activities*. A Report to the Surgeon General Public Health Service by his *ad hoc* Committee on Continuing Education and Training. July 1967:

So that the scope of activities could be studied, the committee clarified the definition of continuing education and training in terms of what it is and what it is *not*. Although there was some difference of opinion, for the purposes of this report, it was agreed that "continuing education and training" is a sufficiently satisfactory term, and that it should be considered to be:

- those educational endeavors which are above and beyond those normally considered appropriate for qualification or entrance into a health profession or an occupation in the health related fields.

Because of the difficulties inherent in applying this definition, the committee offers several criteria which are to be used collectively for determining whether or not a given activity can be considered as continuing education and training.

The primary criteria developed by the committee are that all activities must:

- Be above and beyond basic, core or qualifying preparation for entrance into a profession or occupation and not lead to degree, diploma or certification, and therefore, not part of internship, residency requirements.
- Not provide for career change, e.g. nurse becoming a dietitian, etc.

The activity must meet the criteria where applicable:

- Leading to the assumption of new responsibilities in the chosen career field (supervisory and managerial training).
- Updating knowledge and skills in current field of endeavor (refresher courses).

- Updating knowledge and skills in a different but basically related health field (metropolitan planning for a regional health planner).

If the activity meets the above criteria, it is to be included, regardless of how it is classified for budgetary or other purposes.

In developing this definition the committee acknowledged that it was arbitrarily excluding some educational endeavors which are important for the long-range goal of improvement of the Nation's health including those of the *basic educational preparation* of physicians, dentists, allied health and health-related personnel. It was not because the committee felt that these areas are of less importance or are unrelated to the goal of continuing education, but because their importance warrants consideration in their own right.

Excerpt from *Inventory of Federally Supported Extension and Continuing Education Programs*. Report to the President's National Advisory Council on Extension and Continuing Education. Part one: Report and Recommendations. Prepared by Greenleigh Associates, Inc., March 1967. This definition was made for purposes of conducting a survey. The statement does *not* represent official policy of any Federal agency:

The definitional problems which have to be resolved in any questionnaire were particularly acute for this questionnaire.⁴ There are no standard definitions for extension and continuing education, despite their long lineage. As for the more recently developed "community service programs," there is even less general agreement on the kind of activities which should be under this rubric. A further complication is the fact that Federal support takes many forms: direct or indirect expenditures, grants or subsidies, direct operations or financial support, etc.

Definitional concepts were discussed in a series of meetings with representatives of the council and program administrators throughout the Federal government. During November and December 1966, conferences were held with 25 representatives of 19 departments in nine Federal agencies.⁵

The differences in agencies' understanding and usage were taken into account in formulating definitions and directions for the questionnaire. The questionnaire went through successive drafts, in the course of being pretested with program administrators and council members.

The definitions incorporated in the final questionnaire⁶ refer to extension and continuing education programs and to community service programs in terms of the council's presumed jurisdiction and present interest:

Extension and continuing education programs, including community service programs, as defined here, are certain kinds of federally supported educational programs for adults which continue their education and extend their personal or professional competence.

⁴ They are discussed in the Greenleigh *Preliminary Report*, p. 4, and the Greenleigh *Interim Report*, p. 8.

⁵ See Greenleigh *Interim Report*, "The Definitional Problems," p. 8.

⁶ The questionnaire is reproduced in the Greenleigh final report, *Part Two: Program Abstracts and Indexes*.

(In some instances, extension and continuing education programs are referred to as "community service programs," the terms sometimes being used interchangeably. Other community service programs, which are not ordinarily identified also as "extension and continuing education," are included in this questionnaire only to the extent noted hereafter.)

The programs "assist the individual to meet the tasks imposed by the complexities of our society in fulfilling his role in the world of work, as an informed and responsible citizen, and in his individual growth and development."

The programs may provide personal education, career or job training, or community education. They may be offered by institutions of higher education or by other private or public institutions (private firms, specially constituted agencies, hospitals, public schools, etc.).

Included in this definition are the continuing education aspects of any federally supported program, whether or not continuing education is the major purpose of the program. For example, in certain programs the States may have authority to use Federal funds for staff training as well as for other purposes; to the extent that the Federal agency knows that this option is utilized, *the program should be reported in this questionnaire with reference to its continuing education aspects.*

Excluded from this definition are direct grants (tuition, stipends, other allowances) for undergraduate or graduate study. Although such allowances may be considered "continuing education programs" in another context, they are excluded here.

Community service programs (other than the already defined "extension and continuing education programs, including community service programs") are included in this questionnaire if they are research programs or educational services offered by institutions of higher education.

Should these definitions be altered? In the light of responses to the questionnaire, the council may determine that revisions in the definitions are appropriate, either to enlarge or curtail the council's purview, or to identify the council's purview more precisely.

II. SOME KEY THEORETICAL ISSUES IN INSERVICE TRAINING*

Malcolm S. Knowles, Ph. D.

Professor of Education, Boston University

My plan for this session is to list and describe very briefly a few of the key issues that seem to me to confront us in attempting to construct a co-

*Presented at the Regional Conference on Planning Inservice Training Programs for Mental Health, Swampscott, Mass., Oct. 8-11, 1963.

herent theory of inservice education. Then I should like to involve you in testing this preliminary list, so that you can change it and add to it in the light of your own experiences, concerns, and theoretical orientations. Finally, after we have arrived at a revised list that is mutually satisfactory, we might like to use the remaining time to explore some concepts and principles that might help us in finding resolutions to the issues, or at least to the two or three that seem to us to be most crucial.

Some of the key issues as I see them are these:

1. *What philosophy of education is appropriate to inservice education?* Specifically, what assumptions should we make about the nature of the learner and the nature of the learning process? Are the assumptions that underlie the conventional education of youth transferable to the inservice education of adults, or are a different set of assumptions required? I personally believe that adults are different from youth as learners in certain critical respects, and that these differences in characteristics require us to make certain different assumptions about the adult process of learning. I shall be glad to expose these views later and engage in a dialogue with you about them if you are interested.

2. *What organizational structure should be established for planning and operating inservice education?* Is it strictly a staff function—a set of discrete activities planned and carried out under the direction of educational specialists? Or is it a dimension of the total environment, with responsibilities diffused throughout the structure, both line and staff and at all levels? If the latter, what kind of structure should be created for planning and operating an inservice education program so that all elements of the social system are represented? I have my views on this issue, too, that I shall be willing to discuss with you if you wish.

3. *What needs should be served by an inservice education program?* In traditional practice, inservice training has been perceived as primarily, if not exclusively, an instrument for serving the needs of the sponsoring institution. It has been a means for orienting employed and volunteer workers regarding the institution's purposes, structure, and processes; for inducing acceptable role expectations, for inculcating the institution's values; and for producing appropriate behaviors. Should the institution's needs be controlling? Or will inservice education be successful in the long run only if the needs of the individuals are at least equally satisfied? If the latter, are there any boundaries around the individual needs that can be legitimately taken into account? Should all the needs for self-fulfillment be given consideration, or only those that are job related?

A corollary issue to this one is how should the needs be determined? Is it sufficient that the needs be assessed through such administrative

processes as operational research, personnel appraisal, and supervisory judgments? Are data obtained through performance observations, personality inventories, and projective tests more valid? What part should the individuals' self-assessment of their own needs play? What procedures are appropriate for obtaining such data? I have some ideas about this issue, too.

4. *What should be the objectives of inservice education and how should they be established?* In a sense this is the operational implementation of the issue as to what needs should be served. In its baldest form this issue could be stated as: should the behavioral outcomes of inservice education be those desired by the institution or those desired by the individuals, or some combination of both? If a combination, is one set central and the other peripheral? In case of conflict, which should govern? And by what kind of procedure should the determination be made—administrative decision or some kind of collaborative decisionmaking process? In what form should the objectives be stated? No doubt in the very way I have raised these questions I have revealed that I have a point of view on this issue.

5. *What should be the role of the participants in the inservice education program?* This issue is touched on in issue number 2 on organizational structure, but in the form in which it is raised here it goes deeper into the basic relationship of the learner in the total learning experience. Stated sharply, the central issue is: is the proper role of the participant that of a conscientious absorber of transmitted information or that of a self-directing inquirer? Or some combination of both? The way this issue is decided will greatly affect the design and methodology of a program. On this point, as well, I have some ideas.

6. *What should be the role of the teachers and leaders in an inservice education program?* The resolution of this issue is, of course, dependent upon how issue number 5 on the role of the participants is decided. If the role of the participants is to be that of information absorbers, then the appropriate role of the leadership corps is that of effective transmitters of the required information. But if the role of the participants is that of self-directing inquirers, then the leadership role becomes a much more complicated constellation of the behaviors associated with such roles as those of counselor, consultant, referral agent, resource person, and change strategist.

A corollary issue to this one is: what kind of training should be given to the teachers and leaders of an inservice education program? And what should be the criteria of selection? What supervisory procedures are appropriate?

You can probably tell I'm brimming over with ideas on this issue.

7. *How should an inservice education program be evaluated?* The substantive aspect of this issue will, of course, be decided when issue No. 4 on

objectives is decided. Essentially this substantive issue can be stated: Should the program be evaluated in terms of outcomes to the individuals or in terms of outcomes to the institution, or both? But there is a procedural issue, too, which is: Who should do the evaluating and on the basis of what evidence? Is evaluation an administrative responsibility or a joint responsibility of all those involved in the enterprise? If the latter, by what procedures can they be involved? In either case, what kinds of data will the evaluation be based on and by what procedures will they be collected?

Naturally, I shall bring a point of view into our discussion of this issue.

Now, let me ask you, are these the really crucial issues in inservice education as you see them? Which ones would you like to modify or eliminate? Which would you like to add?

Discussion

After this introduction, the participants formed "buzz groups" to bring forth issues for discussion.

The following are the issues identified by small groups of audience participants, which served as a baseline for discussion.

1. How to translate the amount of knowledge into improved care? How do you select one concept which is important and translate it, and to whom?
2. What should be the purpose and objectives of inservice education?
3. What are the methods for teaching adults? Are they different?
4. How do we motivate people to participate? What are the appropriate and best ways?
5. How do we motivate university faculty? Who do we use as a trainer and who as a consultant, and how do we maintain a continuing interest?
6. How should inservice education be structured into the operation?
7. How is curriculum development best done—in a short intensive amount of time, or over a period of time?
8. Who are the organizations involved, and where do you draw the line?
9. What is inservice education? Is it a change of or in behavior?
10. What should the content of curriculum be for a mental health institution? Would it involve all the disciplines, maintenance, all staff, etc.?
11. Who are the good trainers? Are they educators, or are they the administrators? How do you make the job of trainer attractive?
12. How do you get institution support?
13. Finance—How much and who pays for it?
14. What are the minimum requirements, and where are the people to do it?
15. How do you promote it, and what role does research play in it?

16. Where does the responsibility lie—State agencies, practitioners, schools?
17. After inservice training, what?
18. Categorical or functional problem—What are the appropriate groups or groupings, and how can you accomplish greater unity among the professions and disciplines?
19. Is it better to teach homogeneous groups, mixed groups, or one profession at a time?
20. How do we involve community groups?

Comments by Dr. Knowles:

Probably the key underlying all 20 issues is "What is your philosophy of education?" One philosophy of education will result in different answers than another. On the basis of what we now know of the adult as a learner, most adult educators subscribe to the following propositions as the foundation of their practice. You might wish to check them for consistency with the propositions on which you base your mental health practices.

Learner Sets Own Needs and Goals

Human beings are goal-seeking, need-meeting organisms. Learning is one option available to them in achieving goals and meeting needs, and they will choose this option when they perceive it to be effective for these purposes. *Implication for inservice education:* Learning will be most effective when the employees have diagnosed their own needs and formulated their own goals for learning.

Learner Seeks Answers: Teacher Helps

Learning is a process of reorganization of concepts, feelings, values, etc., within the self. It is wholly an internal process governed by the learner. *Implication for inservice education:* Learning will be most effective when engaged in actively by the employees as a process of self-education (or mutual inquiry); the teacher will most effectively help in this process when he perceives his role not as a transmitter of information but as a facilitator and resource to the employees' inquiry.

Differences Between Youths and Adults

Adults are different from youth (in degree, if not absolutely) in four important respects:

Different Self-Concept

Their self-concept is different. Youths tend to perceive themselves as essentially dependent organisms in the educational situation; they expect to be told what, how, and when to study. Adults, on the other hand, per-

ceive of themselves as responsible, autonomous, self-directing organisms. They tend to resent being talked down to, having decisions made for them, and otherwise being treated like children. When they feel disrespected their ego is threatened and they erect resistances to learning as a defense. *Implication for inservice education:* Employees will feel committed (motivated) to learn to the extent that they are involved in the planning, execution and evaluation of their own learning experiences.

Adults More Experienced

Adults have more experience. Because they enter into a learning activity with broader and richer experience than is typical of youth, adults are themselves a richer resource for learning—and also have a more extensive foundation of experience to which to relate new learnings. *Implication for inservice education:* Those techniques for carrying on the learning-teaching transaction which make use of the experience of the learners will be more effective than those which transmit the vicarious experience of others to the learners. Such techniques include group discussion, case method, sensitivity laboratories, role playing, skill practice exercises, simulation problem solving, team learning projects, audience participation devices, etc.

Task Cycle Differences

Adults have a different cycle of developmental tasks than youth, and therefore, different types and phases of learning readiness or “teachable moments.” Havighurst identifies three main stages of developmental tasks: (a) early adult years (e.g., getting a job, etc.); (b) middle adult years (e.g., getting to the top in the job, etc.); and (c) later adult years (e.g., retiring from the job, etc.). (See Robert J. Havighurst, “Developmental Tasks and Education.”) *Implication for inservice education:* Learning sequences—curriculum organization—will be more effective if geared to adults’ sequences of developmental tasks than if organized according to the logic of subject matter or the needs of institutions. Also, some learning will be accomplished best if the learners are grouped according to homogeneity of developmental tasks.

Application of Knowledge Immediate for Adults

Adults enter into an educational activity primarily with the intention of applying their learnings immediately to the solution of life problems, whereas youth typically have the intention of mastering a body of knowledge for postponed application. As a result, adults tend to be problem centered and practical minded in their orientation to learning. *Implication for inservice education:* The inservice education program will be more effective if it is organized around the actual life problems of the employees than if it is organized around subject-matter topics.

In keeping with this philosophy of education, you will gain the most from this experience if you test the implications of these propositions for the issues you have raised as your own self-inquiry.

Perhaps there are a few issues here that aren't directly covered by these propositions, so I'll toss out a few ideas about them for your consideration.

Definition of Inservice Education

Regarding the issue "What is inservice education?" I might simply point out that those of us who regard adult education as our profession would include all those experiences in a work situation that are designed to influence the growth of employees. Specifically, we would include supervision as a part of inservice education. In fact, in industry the role of the supervisor is shifting away from definition as a controller of human behavior to definition as a developer of human competency. And the training of supervisors is getting to be less concerned with the mastery of techniques of control and more concerned with the mastery of the techniques of education.

Learners Needs and Interests Come First

The objectives of an inservice education program are derived from three sources of needs and interests: (1) The individual employees, as perceived by them; (2) the sponsoring institution, as perceived by its leaders; and (3) society, as perceived by the relevant professions. Adult education always starts with the self-diagnosed needs and interests of the learners, but artistically negotiates for the inclusion of those of the institution and society.

Adult Education Rhythm

Adult education is developing a methodological pattern (or rhythm) of experience-generalization, experience-generalization, etc., that is in contrast to the traditional schoolmaster's rhythm of lecture-discussion, lecture-discussion, etc. We are in an exciting period of invention of new techniques for implementing this rhythm in the adult education field now.

III. INSERVICE TRAINING IN INDUSTRY: THEORY AND PRACTICE*

Louis R. Mobley
Manager of Education
IBM Federal Systems Division

The particular adult education programs I shall examine this evening are the industrial and business educational programs.

Scope of Adult Education

To provide a quantitative setting, it is helpful to note that about \$25 billion are being spent each year on elementary, high schools, colleges and universities in this country. The dollar amount being spent each year within business and industry on education has been estimated from 17 billion to 34 billion. In a Ford Foundation study, Professor Harold F. Clark states that in the United States several times as much is being spent for the education of adults as for all formal education—public and private—from kindergarten through university. There are more students in adult education than in all the schools. It is interesting to note that the total dollars spent each year on health services is also about 25 billion. It is no secret that services like these are the most rapidly expanding sector of this country's gross national product.

Another significant area of adult education for which we have few statistics is covered by the 5,000 national organizations which provide educational programs.

Education vs. Training

Thus far, I have used the word "education." But the title of my subject contains the word "training." It is quite true that most programs of learning in industry are described as "training programs." I have always wondered why we "train" dogs and very young children. Then we "educate" older children and young people. But when they grow up, we "train" adults. Could it be that the rise of widespread education coinciding with the culmination of the industrial revolution resulted in our educating our young people to be mature adults only to employ them in industry which rewards them for behaving like children? The research studies of Chris Argyris described in his book "Personality and Organization" seem to support the thesis that the logic of organization tends to cause employees to be "apathetic, passive, and submissive."

*Presented at the Regional Conference on Planning Inservice Training Programs for Mental Health, Swampscott, Mass., Oct. 8-11, 1963.

Regardless of the extent to which this may have been true in the past, I am convinced that the present transition out of the industrial revolution and into the scientific revolution is forcing a new recognition of the importance of the educated employee working in a business environment which rewards the daring, active, and assertive.

Commissioner Ewan Clague of the Bureau of Labor Statistics, predicts that the pace of change during the remainder of this decade and especially in the 1970's will generate demand for more well-educated, highly skilled workers than will be available. At the same time, he projects rapidly dwindling job opportunities for the unskilled and underskilled.

Based on Bureau of Labor estimates for increases in employment by 1975, farmworkers will *decrease* approximately by 1 million or 20.4 percent. There will be *no* increase in industrial laborers. Skilled industrial workers (operatives, craftsmen, foremen, etc.) will increase by 4.7 million. Clerical workers will increase by 4.1 million (up to 40.6 percent) and professional and technical workers will increase by 4.4 million—the largest *percentage* of any group, (55 percent).

The Professional Employee

Many segments of industry have already moved into the scientific. With the rising demand for highly technical products and the need to produce them, inservice training has become a way of life for the more progressive firms. A new kind of employee has entered industry—the professional employee. He is well educated, mature, creative, and must be managed in a different way from the way unskilled laborers are managed. It seems that the professional employee *must* be managed the way all employees should be managed.

One of the conditions of employment being increasingly demanded by the new employee is an opportunity for continuous education.

THE DEVELOPMENT OF INSERVICE TRAINING IN INDUSTRY

In years past, many industrial companies assumed no responsibility for retraining employees on new work when their skills were no longer needed. They found it easier and less expensive to lay off the unneeded skills and employ the new needed skills. Although this practice is still found among some companies, especially smaller ones, it is not representative of the present-day large company.

"J" Programs

At the start of this century apprentice training was the major formal activity, and this, together with less formalized learning on the job, seemed

to meet the need. World War II created a crisis in industry for which millions of persons had to take on new responsibilities. Industry conducted the "J" programs developed by the War Manpower Commission—job instruction training, job methods training, and job relations training. Although the war ended, problems created by our expanding economy multiplied. The number of individuals involved and the variations in specific job requirements were too great to expect the schools to help much. Industry undertook the educational task itself.

Companies Assume Social Responsibility

Today, when a typical American corporation faces a skill-mix problem, it first considers retraining or transfer rather than layoff. This may appear that companies are assuming more "social responsibility" for employees. Whatever this means, the facts are that industry faces different technical and economic problems and employees are subject to a variety of social developments. Jobs require higher level skills; high investment in initial training encourage employers to retain trained people through upgrading and training; recruitment and employment costs are higher, relatively full employment reduces the supply of available skills; many new skills required are not developed outside the company. At the same time, employee needs and expectations have changed; they are better educated, they want to continue to learn; they tend to identify with the company more, they are more willing to move about the country, making transfers more acceptable; they aspire for professional and management status. The result is more training within industry, both in extent and variety.

EDUCATIONAL OPPORTUNITIES IN INDUSTRY TODAY

It is impossible to convey an accurate picture of training in industry because of the wide diversity of companies. Small companies frequently cannot afford the financial investment required for extensive training and education of its employees. Some large companies do not need extensive programs because of the nature of its business and the economics of its skill requirements or the logics of its personnel practices. Nevertheless, I shall offer some generalities regarding the various types of programs and the kind of companies in which they are found.

Training for New Employees

Almost every company conducts a form of initial training for new employees. When the hiring rate is not great, formal on-the-job instruction usually suffices. Where consistent and sustained employment takes place, more formal off-the-job orientation and initial job training is found. Such training varies from a few hours in the case of nonprofessional skills up to

as much as a year of formal initial training for certain professional jobs like sales and engineering, or in certain specialized skills such as apprentice training. After initial training, those companies undergoing rapid growth and change usually have retraining, upgrading, and refresher-type courses.

Professional Employees

Where relatively large numbers of professional employees are found, advanced courses are offered to prevent professional obsolescence. For these courses, outside educational institutions are frequently utilized for educational programs such as patent attorney training, advanced degree programs for engineers and scientists, and executive development.

Training That Is Company Motivated

Please note that the type of programs described above are company motivated. The company evaluates the work which must be done, its available resources of skill, and determines the training necessary to match skill with work requirements. It then decides whether the training should be in-company or out-of-company on the basis of who can do the best job at the least cost.

Since company-motivated training needs are company determined, these courses are usually conducted on company time and at company expense. To the employee, such training becomes a "job assignment" for the period of the course.

Employee Should Negotiate Training

It is important to note that today the more progressive companies, especially those with many professional employees, do not simply *direct* employees to take such training. Like many job assignments, they are negotiated with the employee, with full consideration given to the employee's interests and ambitions. Many such employees even take the initiative in requesting enrollment in company initiated courses. However, lower skilled, nonprofessional employees prefer to be told what to do and when to do it. For this to work, such employees must have confidence in their management, and such confidence must be maintained through appropriate personnel practices which I shall not explore here.

Voluntary Training

An increasing number of companies are providing for employees' educational opportunities of a voluntary nature. Such courses and programs are offered at company expense because of the longer range value to the company in having better educated employees. But enrollment is strictly voluntary on the part of employees taking the initiative in participating on their

own time. Participation in such educational opportunities frequently qualifies people for better, higher paying jobs. Typical programs of this type are general education night courses, tuition refund programs, extension courses, and management study programs.

Because of the diversity of training activities, a better explanation of current inservice training practices may be made by selecting typical cases of specific programs. The cases chosen illustrate the retraining of nonprofessional manufacturing employees so they may perform different work at higher levels of usefulness and pay.

RETRAINING CASES

Two actual cases can be described in some detail to illustrate the nature of the problem in retraining. Both of these recent experiences relate to the retraining of surplus, unneeded manufacturing skills.

Xerox Corp.*

In 1960 the Xerox Corp., Rochester, N.Y., had made the decision to concentrate its efforts in producing copying machines, and to put less emphasis on its paper manufacturing business. After consultation with union officials, it was decided that the company would retrain at its expense "certain employees with 10 or more years of service in skills which would render them eligible for transfer from the sensitizing plants to the machine manufacturing operations of the company."

Labor-management relations were good. The union very actively encouraged members to enroll in the program, and participated in the planning and operations of the program.

Great pains were taken to insure that employees knew about the program and had the opportunity to discuss its meaning and implications for them. Management and union leadership gave the first official pronouncement of the retraining program to a voluntary Saturday morning mass meeting of employees of the paper division. Following this, every effort was made to publicize the program. The key message was a program that guaranteed an "average" wage (i.e., \$2.66) during training, with a built-in opportunity for learning new skills which would be useful to the company.

Despite such extensive communication, there was a disappointing small number who accepted the offer. Nevertheless, for these who enrolled, a course was given. With the help of the Rochester Institute of Technology, a plan was adopted which provided for 160 class hours of fundamental shop courses, followed by 80 hours of machine shop or assembly practice. The volunteers were given two screening tests (AGCT and Bennett AA). Of 101 persons tested, 34 were unqualified for retraining. Sixty-nine persons were

* "Xerox Corp.—A Case Study in Retraining," Felician F. Foltman, *Management of Personnel Quarterly*, 1962, vol. 1, No. 5.

admitted to retraining and 68 completed the program. Their ages ranged from 27 to 55. Twenty-six had high school education, 39 had less education.

To the union, the retraining program meant an opportunity to make the best of a relatively poor situation. To the management, the program meant a rather sizable investment of funds, incurring a new and sizable financial responsibility, but with an opportunity of assurance of a supply of trained manpower for the years ahead. But to the trainee, the program posed an almost traumatic dilemma: Is this an opportunity or not? What will happen if I do attempt retraining, and what will happen if I don't?

Many trainees were upset by the necessity for personal decisionmaking. "Going to school again" posed adjustment problems which were difficult. The greatest source of dissatisfaction was the arrangement made for replacement after retraining. Administrative delays and lengthy labor pool assignments caused frustration and resentment made worse by the way it was handled. Loss of seniority in the machine operations division was particularly vexing to the trainees.

The principal conclusion to be derived from this case study is that unskilled production workers in a manufacturing industry can be retrained—in a relatively short time—to an acceptable degree of competence for occupations that are not only new to them, but also ranked slightly higher in the skill hierarchy. It was also concluded that administrative practices must be as well planned and executed as the training program itself. Other implications that can be drawn from this particular program are:

1. Inability of employers to guarantee jobs combined with lack of employee knowledge of the occupational hierarchy creates many uncertainties about the employee's future.
2. Employees are interested in immediate economic consequences, not long range.
3. Normal resistance to change can be expected.
4. Fear of being "students" must be overcome.
5. Employees lack confidence in management following through. A "gimmick" is always suspected.
6. Training for adults should emphasize "learning by doing."
7. Testing is a useful screening aid.

IBM Corp.

A specific retraining program in IBM illustrates an approach to the problem of many manufacturing companies today who are faced with rapidly changing technology and the increased use of automation. There is a continued potential problem of plant personnel becoming surplus or technologically obsolete in their skills.

The situation in this case differed from that in the Xerox case in the following respects:

1. The reasons for retraining were related to advancing technology rather than a change in the company product.
2. This is a nonunion situation.
3. The skill level is somewhat higher.
4. Employees are accustomed to participating in a variety of educational programs within the company.
5. No outside educational institution was involved.

This program was conducted at Endicott from September to December 1961 and focused on the retraining of plant personnel on computer electronic technician skills. The basis of selection for the course was:

1. Indicate an interest in being assigned to electronic work by volunteering to take a test battery.
2. Obtain satisfactory grades on the test battery administered by the personnel department.
3. Obtain the recommendation of their manager.
4. Have a high school diploma or equivalent.
5. Have at least 1 year of training in algebra or equivalent individual study.

The test battery consisted of the Wonderlic Personnel Test, the Seattle Algebra Test, and a special company aptitude test.

All those trained (except for six men) were above the 55 percentile of the total plant population. All had IQ's above 100, their average was 113. Ninety percent were high school graduates or better. Ten percent declined to accept the opportunity, mainly because of no interest.

Of the 391 employees enrolled in classes, there were only 21 dropouts.

In order to determine the extent to which the lower half of plant personnel may be retrained, an experimental class of 16 employees was held. The same selection procedure was followed except for eligibility for scores on the test battery. The 16 employees selected were close to the 25th percentile for the total plant.

Of 30 employees invited to take the course, 47 percent declined to accept the opportunity (compared to 4 percent in previous classes). Poor motivation and lack of ability were the main causes for dropout. All dropouts had lower scores on the Wonderlic Test.

From this experience, the following conclusions were drawn:

1. It is possible to retrain a large percentage of employees who score above average on a selection test battery.
2. About half of below-average employees can be trained for highly technical jobs.
3. Motivation for employees to enroll in retraining courses is influenced by their interest, confidence in their ability to succeed, and general plant climate.
4. Below-average employees require longer, more costly courses.
5. Many employees need additional basic education in mathematics and science.

EMERGING PHILOSOPHY OF INSERVICE EDUCATION

Education or Training

As can be inferred from the previous description of industrial inservice training programs, the term "training" is used in connection with those programs which are motivated primarily by and for the benefit of the company. On the other hand, the term "education" is used to refer to those educational opportunities, wherever found, in which the employee takes the initiative to enroll. In other words, education is something the individual does for himself, whereas training is something the company does to the individual.

Balance Between Education and Training

Companies have had enough experience in this field by now to realize that a given program must integrate these two views so that both the company's interests, as well as the employee's interests, are served. Much research has been done on learning theory giving renewed respect for the concepts of self-development and individual differences in relation to learning motivation. If we adhered strictly to the rule of self-development and individual differences, we would never conduct a formal program with groups of people in "classes." On the other hand, if we are completely unconcerned with the concept of self-development and individual differences, there would be little or no motivation for learning. Like most real problems, we must strike the right balance in every learning situation between group and individual, between authority and freedom, between challenge and frustration. The good teacher knows how to maintain these delicate balances.

Growing on the Job

Very few high school graduates, or even college graduates, have reached the degree of maturity when they graduate as they are capable of reaching; formal education seems to systematically remove problems from the learners, thus denying them the essential practice in solving problems; their education has hardly begun; they still have a lot of growing to do. The typical employee, during his first 5 years on the job, needs and wants much direction.

In a spontaneous addition to his prepared remarks, Mr. McElroy covered the following points:

Participation of Trainees Pays Off

A good business proposition is mutually beneficial, mutually agreed to, where each participant in the transaction can strike the fine balance between the group's interests and the individual's interests, between the necessity of authority and the desire for freedom, and between the nature of challenge and the danger of frustration. Every good teacher knows how

to strike these fine balances in specific situations. We are beginning to discover that our managers are as much teachers as they are managers. They are beginning to strike the fine balance between challenge and frustration with their employees, and we are discovering as much training is taking place between the manager and the man right in the manager's office as is taking place in the classroom.

First Job Employees Want School-Like Training

The new employee has to receive an experience somewhat similar to his school experience. We talk about self-development and employee-motivated participation. This is an ideal toward which we hope employees strive, but it does not automatically happen real fast. We have discovered that newly hired employees who have experienced nothing but school life find it extremely difficult to take the initiative. They want to be treated like they were in school. To put it bluntly, they want to be manipulated. They want somebody else to tell them what is expected of them and to hold them to the standards because this is what their teachers did in school. Any kind of experience in the company that departs too much from this may create a problem with the employee. With new employees, and in this area of training, if I can use that term to refer to this kind of experience, the content is usually related to a specific skill or knowledge. Methods tend to be like that found in school; lecture, demonstration, learning by doing, testing, and what have you. These kinds of training experiences tend to be company motivated and company directed.

Capitalize on More Experienced Employees

Now when we find a more experienced, a professional employee or a first line manager, shall we say, we should capitalize on his greater maturity and provide an experience that is not so much like school. He has grown a bit. The experience should be more like work, which is more meaningful to him at the time. It should be less specialized. It should concentrate more on knowledge and attitude and not so much on skills. Its methods should be not so much lecture and demonstration as discussion, problem solving and permissive techniques. The program should be hopefully, individually motivated rather than company motivated.

Executive Education

Moving from the new employee past the professional, more experienced employee into the executive development kind of experience, you might be interested in some of the things we discovered about this kind of individual. The content of this kind of experience needs to be related to the environment of the business—social, political, and economic environment. It needs to focus on the process of decisionmaking. A good gener-

ous dose of philosophy. We have discovered that executives who took philosophy courses in college feel that they did not mean much to them at the time. They are very happy to take a course in philosophy after they become mature because they seem to appreciate it then. Or to put it another way, we simply don't appreciate the answers to problems that we have never had, and unfortunately, our formal educational institutions give us all the answers to all the problems that we never had. But just let a man have a few problems for about 20 years, and he will appreciate these kind of things. We found a tremendous motivation on the part of our executive people at IBM, and other companies, who have had the experience, relate the same story.

There is a thirst for content material relating to political, social and economic matters, philosophy, decisionmaking, and the whole study of values, both qualitative and quantitative in nature. The methods in these programs tend to be extensive reading, discussion, stimulation; the kind of methodology that we don't even find in formal school, except perhaps the reading. An executive doesn't like you to present your paper to him and then discuss it. He wants to read it first, so he can use his time for discussion. This is the reaction we get from executive people.

They like to work hard, but they like to pull away from the job periodically to explore the meaning of their experience and its relevance to themselves, to the company and to the society.

Difference Between Executive Education and Training

It was an English educator who brought up sharply the difference between the education of mature people like executives and the education of less mature people like school children. The education of the executive is a process of differentiation, whereas that of the younger person is a process of acculturation. Perhaps this is the difference between training on the one hand and education on the other. Education encourages differentiation rather than conformity.

Creativity

It's the very difference between people that provides the great possibility of creative interaction between people and is the secret of creativity in this country. In freedom we have the possibility of unlike individuals coming together to discover areas and propositions that are mutually beneficial to both parties. This is possible only when both parties are different from each other. If they were both alike, they could not help each other unless it was to lift twice as heavy a load. Truly creative experiences between individuals in our society come about because of the differences between individuals and the way they interact. When you look at creative phenomena

in biology and in the physical sciences, you discover also that the primary requisite for creativity is that there be an interaction of fundamental differences and new form takes place as a result. For example, positive and negative electricity; the warm, dry air and the cool, damp earth yields growth; the interaction of unique differences.

All of this hullabaloo about conformity goes back basically to the fact that people in specific areas, in specific professions or specific companies are getting too much alike. When people get too much alike creativity begins to drop off and it's the sheer difference between people that makes interaction between them a creative proposition. I am flattered that you invite a representative from industry to your conference because I represent an area of a different set of experiences from that which some of you have had, and hopefully the interaction will be beneficial.

Employees Grow Five Ways

I am going to close with a sort of summary of the way we find people really growing in an organization. This is the whole range of influences that contribute to growth.

1. Self-Development

Now self-development is a rather subtle thing. If you really believe in self-development 100 percent you would never have any classrooms or teachers. You would just leave people alone to develop themselves. It is sort of an ideal that you really cannot reach, and incidentally you can reach it only with very mature people. They have self-determination. They develop themselves—executives really develop themselves. Mature professional people assume responsibility for their own personal development.

I do not like the word motivate. I do not believe you can motivate anybody. I think you can capture their motivation, but I think primarily you can create a set of conditions and environment that will most likely cause them to motivate themselves. I look upon the words "to motivate" as being essentially manipulative. I do not think this is respect for individual dignity, but at the same time I know you have to do more of this with younger people. As they mature, I think you do less and less of it. But for goodness sake, let's not treat mature people like they were youngsters. Let's not go back to training when we ought to be educating for change. This is precisely what I want to see happen with older professional, managerial, mature individuals. I wish we could stop calling this thing inservice training, and start calling it inservice education. They have had their training; they have been youngsters and they have been through school. They have had their education there, but unfortunately there is an awful lot of training going on in our schools.

2. Manager-Man Relationship

The second most important influence on growth in an organizational atmosphere is the manager-man relationship. This is a big story, and I wish I had time to explore it.

3. On-the-Job Enlargement

The third most important influence that will cause self-development to happen is on-the-job enlargement. How do you structure the job in such a way that the employee continually has the opportunity for something new and different and something bigger and better. Now this takes some doing, but it is the manager's job to do it, an administrator's job. As long as you have neat little boxes and you put people in there and say, "This is your job, and don't go outside that box," you are not doing much for job enlargement. We have discovered in IBM that the single managerial effort that pays off the greatest dividend in terms of employee development is continual on-the-job enlargement.

4. In-Service Education

The fourth influence is in-service education, formal training. There is a place for it, especially with the younger, the less mature people.

5. Out-of-Company Experiences

And the fifth kind of opportunity, really a glorious hunting ground for self-development to express itself, is out-of-company volunteer experiences, either in training, education, or in association work—Boy Scouts, Girl Scouts, PTA, Red Cross. They are hungry for leaders. Anybody that volunteers, they will welcome with open arms. The nice thing about working in these kind of activities is you can make all the mistakes you want to, and they will still love you because you are willing. There is no better way of learning than by making a few mistakes. They say a child would never learn to walk if he did not fall down. I do not know whether that is good psychology or not. We feel that mistakes are an important part of the learning process.

A Mentally Healthy Person

If we have a greater respect for education; if we have a greater respect for individual differences; if we allow interaction in a creative way, then we have the conditions for growth. We have the conditions that will cause people to move more toward the direction the Menninger Foundation study presented as sort of a healthy person, a mentally healthy person. You have probably seen this, and I am invading your field, but we find this so absolutely

consistent with the things we have discovered about healthy, mature individuals that I think it is worth repeating.

Five characteristics of a mentally healthy, mature person are:

1. He treats others as individuals by identifying himself and by accepting and understanding them.
2. He is flexible under both internal and external stress.
3. He obtains pleasure from many sources.
4. He sees and accepts his self-limitations.
5. He uses capacities to fulfill personal needs in carrying out productive tasks.

This is a rather respectful list of characteristics of an individual who can enjoy the full measure of individual dignity.

Appendix B

OPTIONAL EVENING SESSIONS QUESTIONS FOR DISCUSSION PURPOSES

OPTIONAL EVENING SESSIONS

Participants were afforded an opportunity on each evening to meet together in small informal groups to discuss special interests or concerns in the field of continuing education. There was no designated leader or discussant in these groups.

There were three groups on Wednesday evening in which a discussant with special knowledge in a particular technical aspect of continuing education was designated to lead the discussion. Attendance at any of the groups was entirely optional. The ground rules established and described in special printed announcements stated that the discussant would be in a designated room at 8 p.m.

Three topics were selected for discussion as follows: (1) "Open-End or Involvement Films" with Mr. Alfred R. Kinney, Jr., chief, Training Methods Development Section, Communicable Disease Center, Public Health Service, Atlanta, Ga., as discussant; (2) "Marshalling McLuhan to Continuing Professional Education: or Do New Means Make Possible New Objectives?" with Mr. Lewis A. Rhodes, director, National Project for Improvement of Televised Instruction, National Association of Educational Broadcasters, Washington, D.C., as discussant; (3) "Programed Instruction: Innovative Opportunity for Continuing Education", with Dr. Theodore H. Blair, Programed Instruction, Inc., Tampa, Fla., as discussant. Due to the small number of participants present for discussion of topics 2 and 3, these two groups joined together and the time was shared by the discussants. Informal feedback from those present indicated that the sessions were lively and instructive.

WARREN C. LAMSON, ACSW

QUESTIONS PREPARED FOR DISTRIBUTION TO EACH GROUP FOR DISCUSSION PURPOSES

Individual and Small Group Aspects of Continuing Education

1. What are the key concepts in a philosophy of education? Which are most unique to continuing education?
2. What can be extracted from learning theory and educational methods? What elements of learning theory should every director of continuing

education know well? For what teaching-learning method is each of these theoretical concepts most meaningful?

3. What behavioral changes in individuals can be reasonably expected in time-limited continuing education activities? How can these be assessed or evaluated?
4. How can the unique contributions of participants, teachers and/or leaders be identified and utilized most positively in an adult learning situation?
5. What should be the investment of the individual learner in his own continuing education? Through what methods?
6. How can appropriate integration and appropriate separateness of continuing education activities involving different disciplines and different levels of experience be achieved?
7. What is the significance of reward systems of various kinds of continuing education?
8. What are the motivational factors involved in an individual's participation or nonparticipation in continuing education programs?
9. In what ways do identity conflicts of individuals and role conflicts of groups complicate the task of continuing education? How can these forces be used to the advantage of continuing education? How can continuing education contribute to a more satisfactory solution?

SCHOOLS, INSTITUTIONS AND AGENCIES

1. What are the most appropriate roles of colleges, universities, specialized training resources, governmental agencies, professional organizations, voluntary groups, industrial organizations, and private institutions in continuing education in mental health?
2. How can realistic goals and priorities be established by institutions and agencies for continuing education programs?
3. What are the factors in institutional and agency programs that facilitate or hinder the development of continuing education programs?
4. What organizational structures should be established for planning and operating continuing education programs? What staffing patterns should be considered?
5. What should be the investment of the employing agency in the continuing education of its employees?
6. How can institutional and agency continuing education programs for mental health personnel be realistically geared to community, State, regional, and national mental health planning and the development of comprehensive mental health services?
7. What is the role of institutions and agencies in evaluating continuing education programs?
8. How can continuing education programs be developed to provide for

maximum flexibility in the use of a variety of approaches, methods, and settings?

9. What factors should be considered in determining the need for continuing education and selecting the individuals or groups to be involved?

COMMUNITY AND STATE PROGRAMS

1. What are the indications for developing selected community or State training centers or other resources for continuing education?
2. How can continuing education programs in communities and States best be administered and coordinated?
3. How can continuing education be developed so that it integrates with, and improves basic training? How can continuing education be oriented to long-range career development rather than relatively isolated blocks of learning?
4. How can community and State programs participate most productively in research and evaluation related to the development of more effective continuing education?
5. How can community and State programs and colleges and universities collaborate most effectively in the development of continuing education programs? What is the most desirable use of university and agency personnel as faculty in continuing education?
6. What is the role of mental health administrators in the development of continuing education?
7. What factors should be considered in securing administrative and legislative support for continuing education?
8. What are the essential elements of a comprehensive community or State continuing education program?

REGIONAL AND NATIONAL PROGRAMS

1. What are the indications for developing selected regional or national training centers or other resources for continuing education?
2. How can regional training resources be best utilized in State, local, and national efforts in continuing education in mental health? What is the special role of such resources in continuing education in mental health?
3. What types of grants or contractual services, other than support of individual continuing education programs should NIMH support in order to foster optimal long-range development in the field?
4. What is the role of regional and national organizations in continuous comprehensive planning for continuing education in mental health?
5. What is the most useful role of regional and national bodies in the development of teaching personnel for continuing education programs?

W.C.L.

Appendix C

EVALUATION QUESTIONNAIRES

Anonymous Evaluation

~~Signed~~ Evaluation and Follow-up

ANONYMOUS EVALUATION

National Conference on Continuing Education in Mental Health October 25-27, 1967

1. I attended scheduled sessions of the conference during the following periods (check as many items as are applicable) :
 - ☐ a. Wednesday morning, October 25
 - ☐ b. Wednesday afternoon, October 25
 - ☐ c. Wednesday evening electives, October 25
 - ☐ d. Thursday morning, October 26
 - ☐ e. Thursday afternoon, October 26
 - ☐ f. Friday morning, October 27
 - ☐ g. Friday afternoon, October 27
2. I have attended regional and national conferences or similar meetings (including annual meetings of associations, etc.) for approximately (check one) :
 - ☐ a. 1 to 5 years
 - ☐ b. 5 to 10 years
 - ☐ c. 11 to 20 years
 - ☐ d. more than 20 years
3. During the past 2 years (since July 1, 1965) I have attended approximately the following number of regional and national conferences or similar meetings (check one) :
 - ☐ a. 1 to 3
 - ☐ b. 4 to 7
 - ☐ c. 8 to 15
 - ☐ d. more than 15
4. My expectations prior to the recent conference, October 25-27 were (check one) :
 - ☐ a. Rather high.
 - ☐ b. About the same as for most conferences
 - ☐ c. Rather low.

5. Compared to my expectations prior to the conference (check one) :
 - ☐ a. I found it better than expected.
 - ☐ b. I found it about the same as expected.
 - ☐ c. I was disappointed.
6. Compared to most other participants, though I cannot be sure, I feel that:
 - ☐ a. I probably got more out of the conference than many of the others.
 - ☐ b. I got about as much as the next person.
 - ☐ c. I probably got less out of it for myself than did most of the participants.
7. Rate each factor listed below on a scale of 1 to 5:

5—excellent	3—average	1—poor
4—good	2—fair	

 (Feel free to add comments to clarify your reactions within any one category listed.)
 - ☐ a. Overall reaction to this conference compared to other meetings I have attended.
 - ☐ b. Timeliness and significance of conference.
 - ☐ c. Objectives clear and realistic.
 - ☐ d. Setting and physical arrangements.
 - ☐ e. Organization and design of conference.
 - ☐ f. Selection of participants.
 - ☐ g. Plenary session presentations.
 - ☐ h. Small group sessions.
 - ☐ i. Background materials.
8. Any comments, for example, elaboration on above responses (items 4-7) or comments on other aspects of the conference?

SIGNED EVALUATION AND FOLLOWUP

National Conference on Continuing Education in Mental Health October 25-27, 1967

1. In what types of content areas did you learn the most? What was new or of most interest to you? From any particular source?
2. What types of content were old stuff or of least interest to you?
3. What contributions that you made did you think aroused most interest in other participants?
4. Did you feel any particular contributions or points of view significant to the field were somehow missed or were not well received by participants who heard you? If so, specify.
5. Do you feel any of your attitudes were significantly changed? If so, which attitudes and by what or whom?

6. Do you feel any prior attitudes were especially strongly reinforced? If so, specify.
7. Were you pleasantly surprised or unexpectedly impressed by any experience at the conference? If so, specify.
8. Were you disillusioned, disappointed or negatively impressed by any experience at the conference? If so, specify.
9. Any additional comments about the conference?
10. In what ways, if any, do you expect your own activities and/or those of your organization will be different during the next year, for which the conference served as a significant stimulus?
11. Suggestions for the future which are afterthoughts or which may have escaped recording or emphasis during the conference? e.g., followup activities which should be fostered by NIMH or other designated organizations?
12. Which questions or issues do you feel most deserve research—with reasonable promise of results?

Appendix D

Roster of Participants

ROSTER OF PARTICIPANTS

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